A Dissertation

entitled

Professional School Counselors' Levels of Self-Perceived Competence Working with Trans* Students in K-12 Public Schools

by

Clark D. Ausloos

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the Doctor of Philosophy Degree in Counselor Education

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Madeline Clark, Ph.D., Committee Chair

_____

Hansori Jang, Ph.D., Committee Member

_____

Tahani Dari, Ph.D., Committee Member

_____

Stacey Litam, Ph.D., Committee Member

_____

Amanda C. Bryant-Friedrich, Ph.D., Dean
College of Graduate Studies

The University of Toledo

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An Abstract of

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Many students who identify as trans* experience discrimination, harassment, and marginalization in their homes, communities, and schools. Professional School Counselors are positioned as pillars of support and advocacy for trans* and gender-expansive youth as dictated by professional standards, however, literature reflects a lack of confidence and competence in working with trans* youth and their families. There is a dearth of professional counseling literature that addresses factors leading to increased school counselor competence with trans* students. The current study proposes to expand this research, through a cross-sectional survey design, surveying professional school counselors in the United States working with students in the K-12 public school system. This study has implications for professional school counselors, CITs, and counselor education programs.

This is dedicated to the 19 identified trans* people who were killed or died this year, based on their gender identity and expression. While this list is not exhaustive, I write their names to honor their stories and remember their lives. Their names must not be forgotten: Dana Martin, Jazzaline Ware, Ashanti Carmon, Claire Legato, Muhlaysia Booker, Michelle 'Tamika' Washington, Paris Cameron, Chynal Lindsey, Chanel Scurlock, Zoe Spears, Brooklyn Lindsey, Denali Berries Stuckey, Kiki Fantroy, Jordan Cofer, Pebbles LaDime “Dime” Doe, Tracy Single, Bailey Reeves, Bee Love Slater, and Ja’leyah-Jamar.

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Chapter 1

Introduction

Gender identity and expression issues and advocacy are increasing in social and political visibility (Flores, Herman, Gates, & Brown, 2016; Herman, Flores, Brown, Wilson, & Conron, 2017, Holzberg et al., 2018; Meerwijk & Sevelius, 2017), and there is an increasing need for ethical, affirming care from healthcare providers and helping professionals (Herman et al., 2017; Singh & Kosciw, 2017), to meet the unique needs of gender-expansive, non-binary, and trans* identities (Asplund & Ordway, 2018; Bemak & Chung, 2008; Cooper et al., 2014; Gonzalez & McNulty, 2010; Goodrich, Harper, Luke, & Singh, 2013; Henry & Grubbs, 2016).

In this study, *trans** is used as a term encompassing a spectrum of gender identities and expressions of those who do not identify with the sex that was assigned to them at birth (transgender, gender-expansive, gender fluid, agender identities; [ALGBTIC, 2009; Ginicola, Smith, & Filmore, 2017; O'Hara, Dispenza, Brack, & Blood; 2013; McBee, 2013]). Trans* individuals face pervasive abuse and assault, discrimination, and societal marginalization (Grant et al., 2011; Herman, Flores, Brown, Wilson, & Conron, 2017; Whitman & Han, 2016), leading to severe physical (ALGBTIC, 2013; Grant et al., 2011; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016) and mental health disparities (ALGBTIC, 2013; Grant et al., 2011; Herman et al., 2017; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016). Historically, trans* individuals avoid seeking care or assistance from professionals (medical providers, counselors, and/or educators) due to discrimination and provider lack of knowledge of gender issues (Bidell, 2012; Benson, 2013; Farmer, Welfare, & Burge, 2013; Grant et al.,

2011; Mahdi, Jevertson, Schrader, Nelson, & Ramos, 2014; Reisner et al., 2014; Riley, Wong, & Sitharthan, 2011; Shi & Doud, 2017; Whitman & Han, 2016). This hesitance to seek services coupled with high levels of oppression, discrimination, and violence indicates trans* persons are critically underserved (Reisner et al., 2014; Riley, Wong, & Sitharthan, 2011; Shi & Doud, 2017; Whitman & Han, 2016).

In schools, trans* students face higher rates of discrimination compared with other students within LGBTGEQIAP+ communities (Association for Gay, Lesbian, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2019; Becerra-Culqui et. al., 2018; O'Hara et. al., 2013; Rosenthal, 2016; Sadowski, 2017) and more frequently face environmental, administrative, and social barriers to success when compared with their cisgender and non-trans* identifying peers (GLSEN, 2007, Kosciw et al., 2018). These experiences make trans* students more vulnerable for mental health disorders, create barriers to social support, increase self-harm, and increase suicidal ideations and suicide attempts (Grant et al., 2011; Hendricks & Testa, 2012; Kosciw, Greytak, & Diaz, 2009; Kosciw, Greytak, Zongrone, Clark, & Truong, 2018; Reisner et al., 2014; Sausa, 2005; Zilcha-Mano, Hungr, Eubanks, Safran, & Winston, 2017). In recent studies, 75% of trans* students reported feeling unsafe at school (Kosciw et al., 2016), while only 13% of LGBTQ students in schools report hearing positive messages about being LGBTQ (HRC, 2018). It is not surprising, then, that suicide attempts among trans* people are nine times higher than rates for the U.S. population (Herman et al., 2017).

The American School Counselor Association (ASCA), the professional association for school counselors, mandates professional school counselors (PSCs) fully affirm and advocate for trans* students (ASCA, 2004, 2016, 2019). The ASCA *Ethical*

Standards for School Counselors (2016) dictate PSCs are "advocates, leaders, collaborators and consultants" who work to create systemic change and provide equitable opportunities and access for all students" (pg. 2). To that end, the standards specifically address PSCs and how they must "understand that students have the right to be treated in a manner consistent with their gender identity and to be free from any form of discipline, harassment or discrimination based on their gender identity or gender expression" (ASCA, 2016, p. 4). An important aspect of a school counselors' role is implementing a preventative, systemic comprehensive school counseling program, using the ASCA National Model (2018), that addresses the needs of all students in development through the academic, career, and social/emotional domains. Additionally, PSCs implement Multitiered Systems of Support (MTSS), including response to intervention (RTI) and positive behavioral interventions and supports ([PBIS], ASCA, 2018). Through the review of data, school counselors identify struggling students and collaborate with other student services professionals, educators and families to remove barriers, and provide appropriate instruction and support.

It is clear that ASCA is prioritizing the needs of trans* students in schools, and PSCs must be prepared to serve these students to work within professional standards of care (ASCA, 2016). Despite this professional requirement, many PSCs report feeling uncomfortable and lack competence in working with trans* students and their families (ASCA, 2016; Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; O'Hara et al., 2013; Mahdi et al., 2014; Shi & Doud, 2017). This proposed study aims to explore factors such as gender, professional experiences with trans* students, post-graduate training addressing trans* issues, and personal experiences with trans* people that

contribute to self-perceived levels of competence of PSCs when working with trans* students in the K-12 public school setting. Results will have implications for PSCs and their work with trans* students, CITs, and counselor education training programs, and counselor education curriculum, including diversity courses.

Statement of the Problem

Trans* students experience harassment, assault, and violence, in and outside of school, often leading to substance use, homelessness, poverty, mental health issues, and an increased risk of suicide (Grant et al., 2011; Kosciw et al., 2018; Reisner et al., 2014). In schools, trans* students experience increased isolation and lower self-esteem, receive lower grade-point averages, have a higher drop-out rate, and are less likely to go to college (Kosciw et al., 2018; Sausa, 2005). Many trans* students feel unsafe at school (HRC, 2018; Kosciw et al., 2017, 2018; National Center for Transgender Equality, 2019; O'Hara et al., 2013; Rosenthal, 2016). Further, many trans* students are required to use a bathroom or locker room that does not match their gender identity and expression (Kosciw et al., 2016, 2017). These lack of facilities invalidates their identity, leading to increased internalized transmisia (the hatred of trans* persons [Simmons University, 2019]), depression, anxiety, post-traumatic stress disorder, substance abuse, and suicidal ideations and attempts (Kosciw, Greytak, & Diaz, 2009; Martinez-Velez, Melin, & Rodriguez-Diaz, 2019; Meyer, 2003; SAMHSA, 2012).

As previously mentioned, ASCA (2016) mandates that PSCs "promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation, gender identity, or gender expression" (para.1), however, researchers indicate that PSCs are not prepared to and are not comfortable working with non-dominant

affective-sexual identities and gender identities (LGBTGEQIAP+), especially when compared with clinical counselors (ALGBTIC, 2019; Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; Mahdi et al., 2014; Shi & Doud, 2017).

While professional standards and ethical mandates assist in providing structure and best-practices (ACA, 2014; ALGBTIC, 2013; ASCA, 2016; CACREP, 2016), researchers continue to find counselor education training programs lack rigor and depth in working with trans* students and clients (Bidell, 2012; Frank & Cannon, 2010; O'Hara et. al., 2013; Salpietro, Ausloos, & Clark, 2019), counselor educators may hold biased and discriminatory views (Frank & Cannon, 2010; Miller, Miller, & Stull, 2007), and there is an absence of quality professional development opportunities on trans* issues (GLSEN, ASCA, ACSSW, & SSWAA, 2019; Salpietro et al., 2019; Shi & Doud, 2017). These combined factors indicate, despite the professional standards of practice (ASCA, 2016), many PSCs never received the training necessary to effectively serve trans* students (Bidell, 2012; Frank & Cannon, 2010; O'Hara et. al., 2013; Salpietro, Ausloos, & Clark, 2019). This lack of preparedness, coupled with trans* students clear socioemotional needs in K-12 school settings (ASCA, 2016; GLSEN, 2007; Kosciw et al., 2018; Russell, Kosciw, Horn, & Saewyc, 2010), indicates an incredible gap in PSCs ability to effectively serve all students, especially those who are the most marginalized in school settings (ASCA, 2016).

Purpose of the Study

A review of the current body of literature reveals that the research foci have been primarily on experiences of students who identify within the LGBTGEQIAP+ spectrum, without specifically focusing on issues related to gender identity and expression

(Goodrich, Harper, Luke, & Singh, 2013; Lloyd-Hazlett & Foster, 2013; Russell, McGuire, Lee, Larriva, & Laub, 2008; Shi & Doud, 2017). While some research has been conducted to address counselor competence in working with LGBTGEQIAP+ students (Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; Mahdi et al., 2014; Shi & Doud, 2017), researchers have not examined the levels of competence of school counselors in working specifically with trans* students (Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; Mahdi et al., 2014; Shi & Doud, 2017). Scholarly literature typically "includes [trans*] people and issues nominally without substantive attention" (e.g., in studies about LGBT+ people broadly; [Moradi et al., 2016, p.1]), and researchers continue to describe trans* persons in studies, "without actually including [trans* persons] within a sample" (Griffith et al., 2017, p. 219). While there has been some literature exploring professional counselors and their experiences with trans* individuals (Salpietro, Ausloos, & Clark, 2019), researchers call for the need for an examination of specific factors that contribute to PSC competence in schools (Greenspan, Griffith, & Murtagh, 2017; O'Hara et al., 2013; Shi & Doud, 2017; Whitman & Han, 2016). With the lack of safety and support for trans* students in schools (Kosciw, Greytak, & Diaz, 2009; Martinez-Velez, Melin, & Rodriguez-Diaz, 2019; Meyer, 2003; SAMHSA, 2012), an increase of mental health needs of trans* students (ALGBTIC, 2013; Grant et al., 2011; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016) and an overall lack of competence of counselors (Bidell, 2005; Day, 2008; Farmer & Welfare, 2013; Graham, 2012; Kosciw, Palmer, Kull, & Greytak, 2013; Singh & Kosciw, 2017), it is necessary to conduct research in this area.

The purpose of the proposed study is to examine factors that contribute to the self-perceived levels of competence of PSCs in working with trans* students in the K-12 public school setting. More specifically, the following factors will be explored: (a) if a PSC has or has not received post-graduate training on trans* issues or populations, (b) if the PSC has or has not worked with self-identified trans* students during their professional work, (c) if the PSC does or does not personally know someone who identifies as trans* outside of the school setting, and (d) PSC gender identity. Knowing which factors contribute to school counselor competence in working with trans* students may help PSCs, CITs (CITs), and counselor educators better understand and implement standardizations in training, provide rigorous and appropriate course curriculum in this area, and understand the most salient factors related to school counselor comfort in working with this vulnerable population. Additionally, better prepared PSCs may lead trans* students in schools to feel less stigmatized, possibly improving academic performance, increasing protective factors, and enhancing trans* students' positive social, emotional and mental health in schools.

Research Questions and Hypotheses

This study aims to answer the following research questions:

Research Question 1

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the Gender Identity Counselor Competency Scale [GICCS; Bidell, 2012; O'Hara et al., 2013])?

H_1: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_{01}: There will be no statistically significant difference ($p > .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Research Question 2

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with trans* students in schools (as measured by scores on the Awareness subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_2: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with trans* students in schools (as measured by scores on the Awareness subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_{02}: There will be no statistically significant difference ($p > .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with

trans* students in schools (as measured by scores on the Awareness subscale of the Gender Identity Counselor Competency Scale [Bidell, 2012; O'Hara et al., 2013]).

Research Question 3

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students in schools (as measured by scores on the knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_3: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students in schools (as measured by scores on the knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_{03}: There is no statistically significant difference ($p > .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students in schools (as measured by scores on the knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Research Question 4

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_4: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_{04}: There is no statistically significant difference ($p > .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Significance of the Study

Extant literature is focused on either LGBTGEQIAP+ persons as a whole, or focuses on students with non-dominant sexual identities, such as lesbian, gay, and bisexual students (ALGBTIC, 2019; Clark & Serovich,1997; Frieze & Dittrich, 2013; Goodrich, Harper, Luke, & Singh, 2013; Goodrich, Catena, & Sands, 2015; Greenspan, Griffith, & Murtagh, 2017; Hartwell et al., 2012; Lloyd-Hazlett & Foster, 2013; Phillips et al., 2003; Russell, McGuire, Lee, Larriva, & Laub, 2008; Shi & Doud, 2017; Singh & Shelton, 2011). Additionally, much literature is focused on trans* adult populations (Blumer, Green, Knowles, & Williams, 2012; Falco, Bauman, Sumnicht, & Engelstad, 2011; Melendez, Bonem, & Sember, 2006; Moradi et al., 2016), while the researcher of the present study aims to highlight the unique and sensitive experiences of PSCs and their work with trans* students in schools. Trans* students, PSCs, CITs, and counselor educators all may benefit from this research, as this research highlights factors that

contribute to PSC self-perceived competence, leading to a safer, more supportive and affirming learning environment. Counselor education programs may use results of this research to inform infusion of gender concepts into curricula, as well as increasing gender concepts and promoting exposure to a variety of diverse populations during practicum and internship experiences.

Definition of Terms

Affirmative Counseling

A positive, strength-based framework for conducting counseling, involving normalizing minority stress, facilitating emotional awareness, regulation, and acceptance; restructuring cognitions, empowering, validating and facilitating supportive relationships (Proujansky & Pachankis, 2014).

American School Counselor Association (ASCA)

The American School Counselor Association (ASCA) is the flagship organization foundation that expands the image and influence of school counselors through advocacy, leadership, collaboration and systemic change (ASCA, 2019).

American Counseling Association (ACA)

"The American Counseling Association is a not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession" (ACA, 2019, para. 1).

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)

A professional division of the American Counseling Association, whose mission includes "the recognition of both individual and social contexts presenting the confluence

of race, ethnicity, class, gender, sexual orientation, ability, age, spiritual or religious belief system, and indigenous heritage" (ALGBTIC, 2019, para 1).

Cisgender

A person who experiences congruence between their assigned sex at birth and gender identity (e.g., they were born with male sex characteristics and they identify as a man [O'Hara et al., 2013]).

Cissexism

Cissexism is the belief that transgender identities are less then, or inferior to the identities of cisgender people, in both covert (eg., using transmisic language, endorsing gender-confirming dress, gender dysphoria as a clinical diagnosis) and overt ways (eg., harassment at work, harassment by police, verbal, physical, sexual assault, hate crimes; LeMaster & Johnson, 2019; Nadal, Skolnik, & Wong, 2012).

Gay-Straight Alliance (GSA)

A student club, often found in schools, that addresses LGBT student issues (Greytak, Kosciw, & Diaz, 2009).

Gender

A set of "social, psychological and emotional traits, often influenced by societal expectations, that classify an individual as feminine, masculine, androgynous or other" (ALGBTIC, 2009, p. 15).

Gender Dysphoria

A diagnosis in the DSM-5, which focuses on "psychological treatment [targeting] coexisting emotional and mental morbidities" and is diagnosed in clients who

experiencing a discord with their gender identity and sex assigned at birth (Houssayni & Nilsen, 2018, p.15).

Gender Identity

"The inner sense of being a man, a woman, both or neither. Gender identity usually aligns with a person's sex, but sometimes does not" (ALGBTIC, 2009, p.16).

Gender Expression

How someone externally display's their gender through dress, behavior, and other factors (Killermann, 2017).

Intersex

"An anatomical variation from the 'standard' male and female types, just as skin and hair color vary along a broad spectrum, so does sexual anatomy" (ALGBTIC, 2013, p.29).

LGBTGEQIAP+

An umbrella acronym used to include: lesbian, gay, bisexual, transgender, gender expansive, queer/questioning, intersex, asexual, ally, pansexual, poly, and many diverse identities, using a "+" or "*" to represent the wide range of sexual orientations, gender identities, and gender expressions that are not included in these acronyms (ALGBTIC, 2013; Astramovich, Chan, & Marasco, 2017; Beagan & Hattie, 2015; Chan & Farmer, 2017; Clark & Serovich, 1997; Hartwell et. al., 2012; Phillips et. al., 2003; Proujansky & Pachankis, 2014; Ward, Dahlhamer, Galinsky, & Joestl, 2014).

Minority Stress

"The higher prevalence of mental disorders [are] caused by excess in social stressors related to stigma and prejudice" surrounding ones' identity/ies (Meyer, 2003, p.24).

Post-graduate training

Training through professional development, workshops, webinars, conferences and other formats, which occur after a counselor has graduated and received their professional license, often related to obtaining continuing education units (ACA, 2019, para. 1).

Sex

Biological factors and refers to the classification of people according to "genetics, anatomy, and physiology" (i.e., male, female, intersex; [Tannenbaum, Greaves, & Graham, 2016, p.2]).

Sexual Orientation

"The sex of those to whom one is sexually and romantically attracted", including, but not limited to, heterosexual, gay, lesbian, bisexual, pansexual, queer, and other orientations (APA, 2012, p.11; GLSEN, 2014).

Title IX of the Education Amendments of 1972

Legislature that "prohibits discrimination based on sex in education programs and activities in federally funded schools at all levels" (U.S. Department of Education, 2015, p.1).

Trans*

“An umbrella term used to describe those who challenge social gender norms, including genderqueer people, gender-nonconforming people, transsexuals, crossdressers and so on.” (ALGBTIC, 2010, p. 16)

Transgender

A person whose gender identity and expression are incongruent with their assigned sex at birth ,“[defying] socially-constructed gender norms” (Ginicola, Smith, & Filmore, 2017; O’Hara et al., 2013, p. 237).

Transmisia

A term which uses the Greek suffix “-misia”, meaning to hate or hatred; essentially defining transmisia as the hatred of trans* persons (Simmons University, 2019).

Transphobia

A term meaning “an aversion, fear, hatred, or intolerance of individuals who are [trans*], or who blur the dominant gender norms…” (ALGBTIC, 2012, p.43; Simmons University, 2019), which is harmful language, reinforcing the stigma associated with mental health disorders and attributes oppression to fear rather than bigotry (Simmons University, 2019).

World Professional Association for Transgender Health (WPATH)

“The World Professional Association for Transgender Health (WPATH), formerly is a 501(c)(3) non-profit, interdisciplinary professional and educational organization devoted to transgender health…funded primarily through the support of our membership, and through donations and grants sponsored by non-commercial sources” (WPATH, 2019, para. 1)

Chapter 2

Literature Review

Introduction

The purpose of this chapter is to provide a thorough review of the existing literature, serving as a rich foundation on which to base the proposed study. First, the author will define important terminology within the LGBTGEQIAP+ acronym (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2019), as well as provide an overview of important terminology related to sexual orientation, gender identity and gender expression. Then, the author will note the prevalence of trans* persons in the United States, and will provide current demographic information related to trans* communities. The author will then note the social, economic, and political determinants that influence trans* physical and mental health.

Next, the author will provide a history of the development of multiculturalism within counseling, followed by important professional multicultural, LGBTGEQIAP+ and trans*-related competencies, standards and ethics, as dictated by professional counseling organizations. The author will then provide a foundation of how PSCs are currently trained to work with trans* students in graduate programs. With this understanding, the author will outline the foundations of roles and expectations of PSCs, and will close by reviewing current literature which addresses current best practices in working with trans* students in schools.

Terminology

When examining the experiences of those who identify as LGBTGEQIAP+, it is important to describe terminology that is used (ALGBTIC, 2013, 2019). Often, non-

dominant sexual and gender identities are grouped together in a way to create a multitude of acronyms. The letters within LGBTGEQIAP+ generally refer to ones' sexual or affective orientation (i.e., lesbian, gay, bisexual, trans*/transgender/two-spirit, gender-expansive, queer/questioning, intersex, agender/asexual/aromantic, pansexual/pan/polygender/poly relationships systems; ALGBTIC, 2013; 2019; GLSEN, 2014). The "T" refers to ones' gender identity and expression (trans*/transgender/two-spirit; ALGBTIC, 2013, 2019; GLSEN, 2014) and the "I" represents people who identify as intersex (ALGBTIC, 2013, 2019). *Intersex* is "an anatomical variation from the 'standard' male and female types, just as skin and hair color vary along a broad spectrum, so does sexual anatomy" (ALGBTIC, 2013, p.29). LGB (lesbian, gay, bisexual), LGBT (lesbian, gay, bisexual, trans*), LGBTGE (lesbian, gay, bisexual, trans*, gender-expansive), LGBTGEQ (lesbian, gay, bisexual, trans*, gender-expansive, queer/questioning), LGBTGEQI (lesbian, gay, bisexual, trans*, gender-expansive, queer/questioning, intersex), and LGBTGEQIA (lesbian, gay, bisexual, trans*, gender-expansive, queer/questioning, intersex, agender/asexual/aromantic), and LGBTGEQIAP+ (lesbian, gay, bisexual, trans*, gender-expansive, queer/questioning, intersex, agender/asexual/aromantic, pansexual/pan/polygender/poly relationship systems) are some of the commonly used groupings, with a "+" or "*" often used at the end of the acronym, to represent the wide range of sexual orientations, gender identities, and gender expressions that are not included in these acronyms (ALGBTIC, 2013, 2019; Astramovich, Chan, & Marasco, 2017; Beagan & Hattie, 2015; Chan & Farmer, 2017; Clark & Serovich, 1997; Hartwell et. al., 2012; Phillips et. al., 2003; Proujansky & Pachankis, 2014; Ward, Dahlhamer, Galinsky, & Joestl, 2014).

It is necessary to examine the differences between *sex* and *gender*, as historically these terms have been used interchangeably (i.e., gender/sex; Tannenbaum, Greaves, & Graham, 2016; Torgrimson & Minson, 2005). The term *sex* relates to biological factors and refers to the classification of people according to "genetics, anatomy, and physiology" (i.e., male, female, intersex; Tannenbaum, Greaves, & Graham, 2016, p.2), while *gender* is generally socially and culturally constructed (Tannenbaum, Greaves, & Graham, 2016; Whitman & Han, 2016). While the term *sex* can be used as shorthand for sexual intercourse, more appropriate terms are anatomical, biological or physical sex to describe the classification (Killermann, 2017). For example, if a person is born with the characteristics of male anatomical sex (testosterone, thick body hair, deep voice, penis), they are assigned male at birth, and are gender socialized as a "male", which is a conflation of gender and sex (Killermann, 2017). If a person's assigned sex at birth and gender are congruent (e.g., they were born with male sex characteristics and they identify as a man), they are referred to as *cisgender* (O'Hara et al., 2013). *Transgender* is a term used to describe a person whose gender identity and expression are incongruent with their assigned sex at birth ,"[defying] socially-constructed gender norms" (Ginicola, Smith, & Filmore, 2017; O'Hara et al., 2013, p. 237). *Trans** is an umbrella term which will be used throughout this dissertation, used to describe a wide range of gender identities and expressions, including transgender, gender-expansive, genderqueer, gender fluid, agender, two-spirit and other gender nonconforming, nondominant identities (McBee, 2013). The author recognizes that gender expansive, nonbinary, and gender non-conforming people all have different lived experiences and expressions, and may not identify as transgender; however, for purposes of this study, the term trans* will be used

for continuity (Griffith et. al., 2017). In the 1960's, the term *gender identity* was created, describing ones' sense of belonging as male or female, but further evolved to include people who identify in a non-binary, fluid, or gender-expansive ways (Lev, 2013).This includes androgynous, transgender, genderqueer, and many other identities (GLSEN, 2014; Lev, 2013). It must be noted that terminology related to sexual orientation and gender identity is evolving and ever-changing, and terminology used herein reflects the literature at this point in time (ALGBTIC, 2013, 2019; GLSEN, 2014).

It is also important to understand the differences between sexual orientation and gender identity (Singh, Boyd, & Whitman, 2010). *Sexual orientation* refers to "the sex of those to whom one is sexually and romantically attracted", including, but not limited to, heterosexual, gay, lesbian, bisexual, pansexual, queer, and other orientations (APA, 2012, p.11; GLSEN, 2014). An individual's sexual orientation is a different identity factor than their gender identity, meaning that gender and sexual orientation are independent of each other (e.g., a person could identity as trans* and heterosexual; Tannenbaum, Greaves, & Graham, 2016; Whitman & Han, 2016).

Current research reflects that both sexual orientation and gender identity exist on spectrums and should be considered fluid concepts (Killermann, 2017; Moleiro & Pinto, 2015). While *gender identity* is used to describe the "internal perception of one's gender…based on how much they align or don't align with what they understand their options for gender to be" (Killermann, 2017, p.263), *gender expression* describes how someone externally display's their gender through dress, behavior, and other factors (Killermann, 2017). For example, someone may have an internal perception of themselves as a female (gender identity) and may choose to display their gender in a

feminine, masculine, or androgynous way (gender expression), demonstrating the complexities and nuances of gender, gender identity, and gender expression. To better conceptualize and understand differences in sexuality and gender, Trans Student Educational Resources (TSER, 2019) developed *The Gender Unicorn*, which categorizes sexuality and gender into various categories: (a) gender identity, (b) gender expression, (c) sex assigned at birth, (d) physical attraction, and (e) emotional attraction. On one or more spectrums, a persons' gender identity is described as female/woman/girl, male/man/boy, and/or other genders, gender expression is described as feminine, masculine, and/or other, physical attraction is described as attracted to women, men, and/or other genders, emotional attraction is described as attracted to women, men, and/or other genders, and sex assigned at birth is described as female, male, and other/intersex (TSER, 2019).

Much of the current literature reflects experiences of LGBTGEQIAP+ persons as a whole, and is especially focused on non-dominant sexual identities (without giving specific attention to the experiences to those who identify as non-dominant gender identities and expressions; Clark & Serovich, 1997; Frieze & Dittrich, 2013; Goodrich, Catena, & Sands et al., 2015; Greenspan et al.,2017; Hartwell et al., 2012; Phillips, Ingram, Smith, & Mindes, 2003; Singh & Shelton, 2011). This is a continued conflation of sexual orientation and gender identity (Killermann, 2017). While persons with non-dominant sexual and gender identities may share similar experiences, gender identity and expression are vastly different from sexual orientation and sexual identity (Killermann, 2017). It is clear that trans* folx deserve attention in literature (O'Brien, 2017) and in practice (Sadowski, 2017).

Trans* Populations

In 2016, about 1.4 million adults (about 0.6% of the adult population) identified as transgender in the United States (Flores, Herman, Gates, & Brown, 2016). Younger adults are slightly more likely to identify as transgender compared to older adults, with "0.7% of adults between the ages of 18 and 24 [identifying] as transgender", and "0.6% of adults ages 25 to 64" (Flores, Herman, Gates, & Brown, 2016, p. 5). More recent data estimates that in the United States, about 150,000 youth (0.7%) between the ages of 13 and 17 identify as transgender (Herman, Flores, Brown, Wilson, & Conron, 2017). The prevalence of trans* youth under the age of 13 is largely unknown (Rosenthal, 2016), as much of the current data on trans* population is mere estimation. Historically gender identity and sexual orientation have not been included in the U.S. Census Bureau's Population Survey (CPS; Holzberg et al., 2018). In fact, for the first time, the 2020 U.S. Census Bureau (USCB) will include relationship questions that ask about same-sex couples, using "opposite-sex husband/wife/spouse", "opposite-sex unmarried partner", "same-sex husband/wife/spouse" and "same-sex unmarried partner" (USCB, 2018, p. 13). However, the USCB intends on continuing to use the binary system for identifying a person's "sex" (male/female), and does not include options for intersex persons, or other gender identities or expression (National LGBTQ Task Force, 2019; USCB, 2018). The National LGBTQ Task Force (2019) created a guide to help LGBTQ persons filling out the 2020 Census, which includes navigating the question about sex: "[trans*] folks navigate this question – and the gender binary itself – every day of their lives. This survey is no different; you can self-identify here in the way that feels most comfortable for you" (p.4). Count the Nation (CTN, 2019) is "a powerful coalition of experts in

media, communications, data, technology and journalism to ensure everyone knows how much census participation benefits their community" (para. 1). CTN and the National LGBTQ Task Force (2019) note the importance of visibility, representation, and an accurate count of LGBTQ persons in the 2020 Census "to ensure fair access to democracy and social services funding" (p. 1).

Future national surveys may yield higher number of trans* people due to people feeling "freer to report that they are [trans*]" due to increasing visibility and awareness of trans* issues (Meerwijk & Sevelius, 2017, p.5). Meerwijk and Sevelius (2017) recommend using standardized questions to identify nondominant, nonbinary, gender-expansive identities allowing for a more accurate estimate, as "under- or nonrepresentation of [trans*] individuals in population surveys is a barrier to understanding social determinants and health disparities" experienced by trans* people (p. 1).

Flores and colleagues (2016) found that the population of adults who identify as trans* "is more racially and ethnically diverse than the U.S. general population" (p.2). The study shows that of adults who identify as trans* nationally, 55% identify as White, 16% identify as Black, 21% identify as Latinx, and 8% identify as another race/ethnicity (Flores, Brown, & Herman, 2016). Researchers also found that adults "who are African-American or Black (0.8%), Latino or Hispanic (0.8%), and of another race or ethnicity (0.6%) are more likely than White adults (0.5%) to identify as transgender" (Flores et al., 2016, p.2).

The National Center for Transgender Equality (2016) conducted a survey, gathering important demographic information for individuals identifying as trans*,

including in their sample "all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and several U.S. military bases overseas" (p. 53). Then, they divided the sample into regions based on the USCB regions (Northeast, Midwest, South, West), and found that 38% of participants live in the South, 24% in the West, 21% in the Midwest, and 18% in the Northeast (James et al., 2016). Regarding income and employment status, almost half (45%) of all participants reported they receive income from multiple sources, such as employment, Social Security income, and/or a pension; while "nearly one in ten (9%) received income from Social Security, including disability…" (James et al., 2016, p. 55). Researchers note that at the time of the survey, the unemployment rate for trans* respondents was three times compared to the U.S. unemployment rate (15% compared with 5%; James et al., 2016). Additionally, trans* persons are three times more likely than cisgender persons to have an annual income of less than $10,000 per year; and trans* persons of color (POC) experience almost four times the national unemployment rate (Price, Wheeler, Seip, & Rush, 2019). High rates of unemployment can lead to a high risk of poverty, with the rate for poverty among trans* persons at more than twice the poverty rate among the general U.S. population (James et al., 2016).

Regarding the intersections of gender identity, expression, ability and disability status, James and colleagues (2016) found that "39% of respondents indicated that they had one or more disability… compared to 15% of the general population" (p. 57). Alarmingly, participants in the United States Transgender Survey (USTS) were six times as likely to report "having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (30%), in contrast to

those in the U.S. population (5%)" (James et al., 2016, p. 57). As data collection for trans* individuals has historically been non-representative and inaccurate (CTN, 2019; Meerwijk & Sevelius, 2017; National LGBTQ Task Force, 2019; USCB, 2018), literature demonstrates there are many important intersecting factors that need attention, including increased attention to trans* persons of color ([POC]; Flores et al., 2016), and the relationship between trans* people, homelessness and poverty (James et al., 2016; Price et al., 2019).

Cissexism and Transmisia

The overarching, pervasive concept of *cissexism* contributes to anti-trans attitudes and perpetuates a culture of fear and marginalization of trans* persons. Cissexism is the belief that transgender identities are less then, or inferior to the identities of cisgender people (LeMaster & Johnson, 2019). This cissexism manifests in both covert (eg., using transmisic language, endorsing gender-confirming dress, gender dysphoria as a clinical diagnosis) and overt ways (eg., harassment at work, harassment by police, verbal, physical, sexual assault, hate crimes; LeMaster & Johnson, 2019; Nadal, Skolnik, & Wong, 2012). Along with cissexism, many trans* persons experience *transmisia*, which uses the Greek suffix "-misia", meaning to hate or hatred; essentially defining *transmisia* as the hatred of trans* persons (Simmons University, 2019). This term is preferred over *transphobia*, deriving from the Greek word "for fear of", which is commonly used in literature, as "an aversion, fear, hatred, or intolerance of individuals who are [trans*], or who blur the dominant gender norms…" (ALGBTIC, 2012, p.43; Simmons University, 2019). Using transphobia to label oppression is harmful in that it reinforces the harmful stigma associated with mental health disorders, attributes oppression to fear rather than

bigotry, and implies that the actions are outside of the oppressors' control (Simmons University, 2019). This sociopolitical marginalization impacts the daily lived experiences of trans* persons (Nadal, Skolnik, & Wong, 2012).

Social Determinants and Health Disparities

Individuals who identify as trans* experience pervasive stigma, social marginalization and discrimination in almost every part of their lives, including at home, in the workplace, and at school (Grant et al., 2011; James et al., 2016; Whitman & Han, 2016). Crenshaw (1991) developed the term intersectionality to discuss "the interconnected nature of cultural identities, systems of oppression, and the power, privilege, and marginalization that may result" (Chang, Singh, & dickey, 2018, p. 14). Factors within intersectionality (gender, race, social class, sexual identity, gender identity) "simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions" (Cole, 2009, p.179). Violence towards trans* people, especially those who have intersecting identities (i.e., transwomen of color, transpersons with disabilities), is common (HRC, 2019).

The marginalization of non-dominant gender identities, ranges from "microaggressions up to and including the threat or actuality of physical violence, even death" (ALGBTIC, 2013, p.4; Nadal, Skolnik, & Wong, 2012). Trans* individuals experience high rates of domestic violence, physical abuse, and sexual assault (Grant et al., 2011; James et al., 2016; Whitman & Han, 2016) and are often abused by their families of origin or forced to leave their homes because of their gender identity (James et al., 2016). Because of this lack of family support, it is not uncommon for trans* people to face poverty and homelessness at some point in their lives (Grant et al., 2011; Reisner

et al., 2014). SAMHSA (2012) reports up to 60% of trans* people experience physical abuse, while up to 66% of trans* people experience assault. These crimes are often under-reported, especially among those with intersecting identities. In 2018, advocates tracked at least 26 deaths of trans* people in the United States who were mostly young trans* women of color (HRC, 2019). The impact of the intersection of race and gender identity is also seen in rates of homelessness (James et al., 2016), with about 41% of black trans* people experiencing homelessness at some point in their lives, "which is more than five times the rate of the general population" (HRC, 2019, p. 22).

Additionally, trans* people with disabilities are significantly more likely to avoid public accommodations compared with their non-disabled counterparts, including stores, restaurants, and public transportation (Singh & Durso, 2017). Respondents who identified as trans* from one study were almost four times as likely to report challenges while doing errands by themselves (doctor's office, grocery store) because of a "physical, mental, or emotional condition" when compared with the U.S. general population (James et al., 2016, p. 57)

There are many challenges within the workplace for trans* people, with almost 78% of respondents indicating they experienced mistreatment or discrimination in the workplace (Grant et al., 2011). Challenges include hiring biases, wage inequities, on-the-job discrimination, unclear legal protections, an inability to update legal documents, unequal access to health insurance, and denial of personal medical leave (Movement Advancement Project [MAP], Human Rights Campaign [HRC], & Center for American Progress [CAP], 2013). Trans* individuals face concerns on how to dress and how to assert usage of their pronouns in interviews and at work; additionally, trans* people who

may not be visually "conforming" to a gender may face overt discrimination, "despite having outstanding qualifications" (MAP, HRC, & CAP, 2013, p. 13). Trans* individuals who hold non-dominant racial-ethnic identities experience higher rates of job loss due to their gender identity than white people, with the highest being American Indian (21%), Multiracial (18%), and Black (17%) trans* persons (James et al., 2016). This intersection of ability status, race and ethnicity, sexual orientation, and gender identity can contribute to multiple minority stress (Meyer, 2003). Meyer (2003) proposed a minority stress model which explains "the higher prevalence of mental disorders [are] caused by excess in social stressors related to stigma and prejudice" surrounding ones' identity/ies (p.24). These multiple minority stresses can be extremely burdensome for trans* with intersecting marginalization.

Unfortunately, many trans* individuals are not afforded protections under the law. The Equal Employment Opportunity Commission (EEOC) ruled on extending Title VII of the Civil Rights Act of 1964's prohibition on sex discrimination to include trans* and gender-expansive persons, however "EEOC rulings are not binding on private employers and federal courts may rule differently" (MAP, 2019). Currently, only twenty one states, two territories, and the District of Columbia have law that explicitly prohibits discrimination based on sexual orientation and gender identity and expression, two states explicitly interpret existing law to include gender identity, one state prohibits discrimination based on sexual orientation only, while twenty six states and three territories have "no explicit prohibitions for discrimination based on sexual orientation or gender identity in state law" (MAP, 2019, para. 1).

Physical health determinants. While research is still limited on health disparities due to inaccurate and lack of representation of trans* persons in systematic collections of data, literature reflects a connection between poverty and poor health (Martinez-Velez, Melin, & Rodriguez-Diaz, 2019). As previously stated, poverty is common among trans* individuals, contributing to challenges in accessing proper healthcare, including the inability to afford health insurance which can lead to a lower quality of life, often forcing trans* individuals into unsafe work environments and roles (i.e.., sex work; Martinez-Velez, Melin, & Rodriguez-Diaz, 2019). Respondents from the National Transgender Discrimination Survey (NTDS, 2015) report having participated in sex work (10.8%), and some (2.3%) report they have traded sex for a place to stay. Individuals identifying as Black and Black Multiracial report the highest rates of sex work (39.9%), followed by Latinx (33.2%), with "white only" respondents having the lowest rate of sex [work] participation (Fitzgerald, Elspeth, Hickey, & Biko, 2015, p. 4). Additionally, those who identified as transfeminine were twice as likely (13.1%) to participate in sex work compared with those identifying as transmasculine (7.1%; Fitzgerald et al., 2015). Also concerning are HIV rates among trans* people with sex work experiences: 40.6% of Black and Black Multiracial report being HIV+, compared with 7.0% of Black and Black Multiracial non-sex workers (Fitzgerald et al., 2015). In addition to increased rates of HIV, Black trans* people have higher rates of smoking, drug and alcohol use and suicide attempts when compared with the general US population (Harrison-Quintana, Lettman-Hicks & Grant, 2011). Another detriment to trans* individuals physical health is the extreme injury, violence, and sexual assault they endure, especially trans* folx with intersecting identities (i.e.., POC, ability status, social class, socioeconomic status), as

well as the prominence of intimate partner violence among couples with a trans* partner (ALGBTIC, 2013; Grant et al., 2011; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016).

While trans* persons experience pervasive physical and sexual violence, many report negative experiences with health care providers due to being trans* (harassment, refusal of treatment) and avoid seeking healthcare from providers (James et al., 2016). Additionally, many trans* people are denied coverage for care related to gender transitioning, including hormone treatment and transition-related surgeries (James et al., 2016). These factors contribute to poor physical health outcomes for trans* people (ALGBTIC, 2013; Grant et al., 2011; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016). Huebner and Davis (2007) assert that ignoring or failing to acknowledge discrimination can lead to an increase visits to doctors' offices, sick days, and even nonprescription drug use. Reisner and colleagues, and the Project Voice Team (2014) examined three stress-related physical health outcomes, and found that trans* people experiencing discrimination in and around public accommodations predicted an increased risk of experiencing physical symptoms (headache, upset stomach, tensing of muscles, pounding of heart), being diagnosed with asthma, and being diagnosed with a gastrointestinal issues (i.e.., Chrohn's disease, colitis, IBS).

Mental health determinants. In addition to physical health outcomes, the trans* population are more vulnerable to a variety of mental health conditions. James and colleagues (2016) found that 39% of participants experienced serious psychological distress which is "nearly eight times the rate in the U.S. population" (5%, p.103). Due to the reinforced binary view of gender identity (male or female), many trans* people feel

pressured to “pass” as their authentic gender identity to avoid negative consequences, increasing their overall levels of stress and gender dysphoria (Patev, Dunn, Hood, & Barber, 2019). In the 1980’s, Gender Identity Disorder (GID), was added as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders ([DSM; Houssayni & Nilsen, 2018), further stigmatizing trans* clients. *Gender Dysphoria* is a diagnosis found in the fifth edition of the DSM (DSM-V), which focuses on “psychological treatment [targeting] coexisting emotional and mental morbidities” and is diagnosed in clients who experiencing a discord with their gender identity and sex assigned at birth (Houssayni & Nilsen, 2018, p.15). Authors note a slight shift in the newest edition of the DSM (DSM-5), from treating pathology to being supportive and accepting of trans* clients identity (Houssayni & Nilsen, 2018), however this view is not shared by all practitioners and many trans* people continue to feel marginalized, and discriminated against in health settings (ALGBTIC, 2013; Grant et al., 2011; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016).

This persistent social discrimination and abuse have a harmful effect on trans* individuals’ physical and mental health, contributing to a higher prevalence of physiological issues, and mental disorders, including internalized transmisia, depression, anxiety, and PTSD (Martinez-Velez, Melin, & Rodriguez-Diaz, 2019; SAMHSA, 2012). Meyer (2003) discusses how greater minority stress of LGBT persons, “the greater the impact on mental health problems” (p.9). Alienation, lack of integration in the community and problems with self-acceptance are related to depressive symptoms, substance abuse, and suicidal ideations (Meyer, 2003).

Trans* individuals experience disproportionate rates of substance abuse compared to the general population, often as a way to cope with pervasive discrimination (Reisner et al., 2014; SAMHSA, 2012). Marijuana, crack cocaine, and alcohol are used most frequently by trans* folx, while some studies have found high rates of methamphetamine use and injection drug use (SAMHSA, 2012). However, access to substance abuse treatment is often challenging due to discrimination and binary segregation by gender within treatment programs (SAMHSA, 2012).

Most alarming are the statistics surrounding suicide among trans* people. Of all trans* adults, 48% have considered suicide in the past year, compared with merely 4% of the United States (U.S) population (NAMI, 2019). In the most recent U.S. Transgender Survey (2016), rates of actual suicide attempts among trans* persons are nine times higher than the rates for the overall U.S. population (Herman et al., 2017).

Challenges for Trans* Students

Among all the types of identities under the LGBTGEQIAP+ umbrella, trans* students face the greatest risks "physically, psychologically, and academically at school" and are often "the last group…to have their needs addressed" even in schools with anti-bullying policies and Gay-Straight Alliances ([GSA]; Sadowski, 2017, p.81). Among trans* students specifically, there is a higher prevalence of anxiety, depression, attention deficit disorders, self-harm, suicidal ideation, and substance use disorders compared with their cisgender counterparts (Becerra-Culqui et. al., 2018; O'Hara et. al., 2013; Rosenthal, 2016). Trans* students report experiencing social and institutional discrimination and verbal and physical harassment in various environments, specifically in K-12 educational settings (HRC, 2018; Kosciw, et al., 2016), resulting in limited

access to transportation, housing, and medical resources to transitioning (Brennan et. al., 2017).

In schools, trans* students face more pervasive marginalization than their cisgender counterparts, including restrictions and regulations in classes, on athletic teams, and at social and sporting events (GLSEN, 2007; HRC, 2018; Kosciw et al., 2009, 2016, 2018). Trans* students are often denied use of school bathrooms and locker rooms that match their gender identity, are frequently misgendered, and often are denied the use of their personal pronouns (GLSEN, 2007; HRC, 2018; Kosciw et al., 2009, 2016, 2018). Trans* students experience violence, as well as isolation, leading to lower self-esteem, lower grade point averages, and are therefore less likely to go to college and have a high drop-out rate from school (Kosciw et al., 2014; Sausa, 2005). Of trans* students who identified they were considering dropping out of school, 33.9% indicated "that they were doing so because of the hostile climate created by gendered school policies and practices" (Kosciw et. al., 2017, p.xxi).

In a recent study, 75% of trans* students reported feeling unsafe at school, 70% said they avoided bathrooms, and 60% had been required to use a bathroom or locker room that did not match their gender identity (Kosciw et al., 2016). The Human Rights Campaign (HRC) found that only 13% of LGBTQ students in schools report hearing positive messages about being LGBTQ (2018); and only 10% of LGBT students report having a comprehensive anti-bullying policy that includes gender identity and expression (HRC, 2018; Kosciw et al., 2016). It is important to note that trans* students do not face discrimination only from their peers; often school administration, teachers and other stakeholders refuse to respect students' gender identities and are sometimes punishing of

them for their gender expression (National Center for Transgender Equality, 2019). Because of this lack of support, trans* students may develop anxiety, depression, and substance use disorders (O'Hara et al., 2013; Rosenthal, 2016).

The presence of organizations in schools, such as gay-straight alliances, or gender and sexuality alliances (GSA), have considerable benefits for students and allies (GLSEN, 2007). However, more research is needed that examines the experiences of trans* students and their perceptions of support within these organizations (GLSEN, 2007; Kosciw et al., 2018). The latter is particularly important, given that school policies *must* include attention to sexual orientation and identity, as well as gender identity and expression (ASCA, 2016; Russell, Kosciw, Horn, & Saewyc, 2010), while, in reality, they often do not.

As trans* students spend most of the day in the school environment, unsafe and disaffirming attitudes and policies can have a major impact on mental wellbeing. In fact, research demonstrates that the presence of supportive and affirming school staff of LGBTGEQIAP+ youth has the strongest positive effect on the school climate, even compared with supportive student clubs, LGBTGEQIAP+ -inclusive curricula, and comprehensive anti-bullying and harassment policies (Kosciw, Palmer, Kull, & Greytak, 2013). Therefore, PSCs play a pivotal role in the success and well-being of LGBTGEQIAP+ students in schools (Singh & Kosciw, 2017).

Important Legislature and Legal Issues Impacting Trans* Students

While school systems and school counselors can provide support and affirmation to an extent, trans* students continue to experience direct human rights violations, and barriers to their development and authentic expression through local, state and national

legislation (American Civil Liberties Union, 2019; Freedom For All Americans, 2019; Movement Advancement Projet, 2017; U.S. Department of Education, 2015; Wang, Solomon, Durso, McBride, & Cahill, 2016; Wynn, 2015).

Title IX of the Education Amendments of 1972 "prohibits discrimination based on sex in education programs and activities in federally funded schools at all levels" (U.S. Department of Education, 2015, p.1). This protects students and other school personnel from discrimination, including "discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity" (USDOE, 2015, p.1). Within schools, Title IX applies to recruitment, admissions, and counseling of students; financial assistance, athletic benefits, opportunities and financial assistance, sex-based harassment, pregnant and parenting students, discipline, single-sex education in classes and extracurricular activities, and retaliation (USDOE, 2015). Despite the 2017 decision from the Department of Education's Betsy DeVos and Attorney General Jeff Sessions to rescind guidelines that clarified schools' obligations in protecting trans* students from discrimination, Title IX "still protects transgender students, as well as LGB students through sex stereotyping protections…and students are entitled to access their education free from discrimination and can file a complaint with [the Departments of Education] if these rights are being violated" (Dashow, 2017, para 5).

While there has been an increase in support and ally-ship for trans* people, there has been an increase in harmful anti-trans* legislature that target and further marginalizes this population (MAP, 2017). This legislature often proposes "barring access to or even criminalizing the use of appropriate facilities, including restrooms, restricting [trans*] students' ability to fully participate in school, authorizing healthcare discrimination

against [trans*] people, allowing religiously-motivated discrimination against [trans*] people, or making it more difficult for [trans*] people to get identification documents with their name and gender" (ACLU, 2019, para.6). In 2016, North Carolina Governor Pat McCrory signed into law House Bill 2 (HB2) which amended state law and forced schools and public facilities to only allow use for people whose gender identity and expression matched their sex assigned at birth (Carcaño, 2019). In 2019, U.S. District Judge Thomas Scroeder ruled in favor of the American Civil Liberties Union (ACLU) and bars legislation that prevents trans* people from using restrooms that are in accordance with their gender identity (Carcaño, et al. v. Cooper, et al., 2019). In Texas, House Bill (HB) 1748 was proposed to ban discrimination on the basis of gender identity and expression, and, although it did not pass, the Houston Equal Rights Ordinance (HERO) was repealed by popular vote, stripping legal protection against discrimination on the basis of gender identity (Wang, Solomon, Durso, McBride, & Cahill, 2016). Another bill (which was later defeated) was proposed in Kentucky, aimed at overturning a decision to allow trans* students at Atherton High School to use which facilities were congruent with their gender identity and expression (Wynn, 2015). While this is a victory for trans* people, legislature continues to be introduced in states that minimizes and removes protections. In 2019, HB5 was proposed in Arkansas, which prohibits state funded sex change operations, and in Illinois, HB3515 prohibits medical doctors from prescribe, providing, administering, or delivering puberty-suppressing drugs or cross-sex hormones, and performing transition-related surgeries (Freedom For All Americans, 2018).

As is evident, there continues to be abuse, discrimination and marginalization of trans* individuals at various levels in society, from homes, schools, and places of employment (Grant et al., 2011; HRC, 2019; James et al., 2016; Whitman & Han, 2016), to disaffirming and incompetent providers and professionals (ALGBTIC, 2013; Grant et al., 2011; Huebner & Davis, 2007; James et al., 2016; SAMHSA, 2012; Whitman & Han, 2016), to imbedded systemic transmisia through anti-trans* legislature (ACLU, 2019; Freedom For All Americans, 2019; MAP, 2017; USDOE, 2015; Wang et al., 2016; Wynn, 2015); all factors that contribute to negative mental and physical health outcomes for trans* students.

Professional Counseling Standards

This section will include a historical foundation of diversity concepts and multicultural counseling competencies in counseling, and the development of professional standards and best practices from the late 1980's until today. Included in this section are standards and ethics published by the American Counseling Association (ACA), the American School Counselor Association (ASCA), the World Professional Association for Transgender Health (WPATH), and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC).

Multicultural Counseling Competencies and Ethical Standards

Starting in the late 1980's and 1990's, professional counselors saw a need for increased attention to diversity in clinical and educational settings (Ancis & Marshall, 2010; Ancis & Ladany, 2001; Sue, Arredondo, & McDavis, 1992). Increasingly, counselors were diagnosing and treating individuals who differed culturally from themselves. At that time, scholarship focused on racial and ethnic diversity in counseling,

and mainly examined the relationship between a professional counselors' ethnocultural identity and that of their client(s). In the early 1990's, counselor-researchers developed and proposed the first Multicultural Counseling Competencies and Standards (MCCs; Sue, Arredondo, & McDavis, 1992). These competencies addressed aspirational counselor characteristics as well as domains that are appropriate for ethical multicultural counseling. These characteristics included counselor self-awareness, counselor awareness of clients' world view, and culturally sensitive interventions; corresponding with domains of counselor awareness/attitudes and beliefs, counselor knowledge, and counselor skills (Sue et al., 1992). These MCCs were intended to be used with a variety of diverse populations (Sue et la., 1992).

Almost twenty three years later, these competencies were adapted and refined to include social justice and advocacy domains (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015), which are essential components of a professional counselors' development and identity (ACA, 2014; ACES, 2011; ASCA, 2016; CACREP, 2016) in the *Multicultural and Social Justice Counseling Competencies* (MSJCCs). The expanded MSJCCs include the *counseling relationship* as an important part of competent multicultural counseling, in addition to counselor self-awareness, client world view, and culturally sensitive interventions (Ratts et. al., 2015). This is an important addition to counselors work with trans* clients, as there is a significant relationship between the counseling relationship, or *therapeutic alliance*, and positive outcomes in counseling sessions (Hilsenroth & Cromer, 2007; Israel, Gorcheva, Walther, Sulzner & Cohen, 2008; Zilcha-Mano et al., 2016). The therapeutic alliance is "the emotional bond established in the therapeutic dyad and the agreement between patient and therapist concerning therapy

goals and the tasks necessary to achieve them" (Zilcha-Mano et al., 2016, p.484). The stronger the alliance between counselor and client, the better the therapeutic outcomes (Zilcha-Mano et al., 2016). Israel and colleagues (2008) found that, "the therapeutic relationship emerged as a crucial variable that characterized both the helpful and unhelpful situations, as well as their consequences" (p.366). Examples of unhelpful situations in the aforementioned study include mistrust of the therapist, lack of competence by the therapist in working with LGBT issues, the therapist imposing their values on the client, and the client experiencing the therapist as uncaring, cold, or disengaged (Israel et al., 2008). In these cases, the therapeutic alliance deteriorated and some clients terminated counseling prematurely (Israel et al., 2008). Conversely, in helpful situations, the therapeutic alliance is defined by accepting, validating, and affirming actions by the counselor toward the client (Israel et al., 2008).

Another important addition to the expanded MSJCCs is *action,* as a form of social justice and advocacy (Ratts et al., 2015). Given the history of discrimination and corresponding health disparities among trans* youth, advocacy at the individual and global levels is an important and necessary component of professional counselors' work (Astramovich, Chan, & Marasco, 2017). The updated MSJCCs gave increased attention to diversity and a stronger framework from which to foster multicultural competency, through counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions (Ratts et. al., 2015).

Professional standards and competencies allow for a unified voice of a profession, a theoretical framework, and a standardized way of working with clients. However, there is often a lack of pragmatic application of these standards. Professional counseling

organizations dictate through standards and best practices, that multiculturalism must be infused into professional clinical and school counseling, as well as counselor education programs (ACA, 2014; ASCA, 2016; CACREP, 2016).The American Counseling Association (ACA), and the American School Counselor Association (ASCA), are two examples of organizations that discuss the application of multicultural foundations, namely calling for an awareness of a counselors' own cultural identity and cultural biases, and the ethical and just treatment of diverse clients and students with whom they work (ACA, 2014; ASCA, 2016). In 2003, the American Counseling Association Governing Council endorsed Advocacy Competencies which provide a foundation of domains from which to advocate, including acting with or acting on-behalf of students and students, from the micro- to the macro-level (Lewis, Arnold, House, & Toporek, 2003). Lewis and colleagues (2003) posit how advocacy involves "not only systems change interventions but also the implementation of empowerment strategies in direct counseling" (p. 1). In 2018, Toporek and Daniels expanded the advocacy domains to include "focus of counselor energy" as a continuum from direct system intervention to supporting client and client groups (p.3). Authors note that clients continue to face challenges with themselves and their families and the updated standards " [reflect] the increasing engagement of individuals, communities and schools in social action and [enhance] the ways that counselors can work to support those efforts through advocacy and collaboration" (Toporek & Daniels, 2018, p. 10). Advocacy actions with trans* clients may include fostering client development of self-advocacy skills, assisting clients in the development of support networks, identifying and challenging systemic

discrimination, and working to promote social and legislative change that honors inclusivity and wellness among trans* people (Astramovich, Chan, & Marasco, 2017).

Trans* Health and Mental Health Models

The World Professional Association for Transgender Health (WPATH) is "an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health" (2019, p. 1). WPATH aims to promote the highest standards of care through publishing the Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People" (Coleman et al., 2011). The goal of the SOC is to "provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" (Coleman et al., 2011, p. 1). While the standards do address mental health assessment and counseling, they are mainly focused on primary medical care, gynecologic and urologic care, hormonal and surgical treatments, and do not address issues within schools (Coleman et al., 2011). In schools, PSC duties do *not* include diagnosis or "providing therapy or long-term counseling in schools to address psychological disorders" (ASCA, 2019, para. 1). Therefore, it is essential that researchers continue to explore the unique experiences of PSCs, so they can better work with trans* students, their families, and community systems.

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) created *Competencies for Counseling with Transgender Clients*

(2009). These competencies recognize the historic marginalization and bias through assessment, and authors are intentional in language that de-pathologizes trans* people by putting "disorder" in quotes throughout the competencies (ALGBTIC, 2009, p. 4). Unique to these standards is the focus on training standards and multicultural and social justice issues as important factors in work with trans* clients (Singh, Boyd, & Whitman, 2010) . The standards are organized through each of the eight training domains put forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2008). While institutional accreditation examines the university-system as a whole, specialized accreditation specifically examines preparation programs within universities (CACREP, 2019). The Association of Specialized and Professional Accreditors (ASPA) promotes that program accreditation assures that personnel and programs meet certain levels of quality, excellence and professionalism (ASPA, 2013). CACREP requires counseling programs to follow manualized steps in the accreditation process, including writing and submitting a self-study and preparing for an on-site visit with an accreditation representative (CACREP, 2019). The ALGBTIC Competencies (2009) attend to the CACREP (2009) domains of: human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle development competencies, appraisal, and research. Authors note the competencies are strength-based, and focus on wellness and resilience, through a lens of multiculturalism, social justice, and feminism (ALGBTIC, 2009). Similar to the ACA Advocacy Competencies (Toporek & Daniels, 2018), the ALGBTIC *Competencies for Counseling with Transgender Clients* (2009) "acknowledge the influence of privilege, power and oppression on clients' lives" and provide ethical ways to assess, document,

and work to meet the needs of trans* clients (p. 2). Important to note, however, is a major limitation of these competencies: they are not focused on youth, older adults, working with family members, and do not attend to issues related to schools (ALGBTIC, 2009).

In 2012, ALGBTIC created additional LGBQQIA competencies for working with lesbian, gay, bisexual, queer, intersex, questioning and ally populations, organized into domains according to CACREP (2009) Standards (ALGBTIC, 2013). Authors understand the continual evolution of LGBTQIQA communities and hope "that these competencies will be revised as needed to reflect these changes, and that research and work will continue to promote further inclusivity" (ALGBTIC, 2013, p. 8). While the LGBQQIA Competencies (2012) provide a framework for fostering personal, social, emotional and relational growth and development, they clearly outline that trans* people are not addressed in the standards and direct readers to utilize the *ACA Competencies for Counseling with Transgender Clients* (ACA, 2010; ALGBTIC, 2013).

Counselor Training and Preparation

Many of the aforementioned standards and competencies are structured in a way for both practitioners to use in practice, as well as in counselor education training programs, as a "framework for training, practice, research, and advocacy within the counseling profession" (ALGBTIC, 2013, p. 2); and while these call for the inclusion of LGBTGEQIAP+ issues within diversity courses, and infused throughout counselor education curricula, the reality is that CITs receive minimal training in working with LGBTGEQIAP+ clients, specifically trans* and gender-expansive clients (Bidell, 2012; Frank & Cannon, 2010; O'Hara et. al., 2013). Bidell (2012) notes that while multicultural course work in graduate training programs increases cultural counseling competency,

more research is needed on how these courses prepare students, specifically PSCs, in working with LGBTGEQIAP+ clients. Additionally, research has demonstrated instructors within counselor education "lacked attention to and competency with trans*-related issues" (Salpietro, Ausloos, & Clark, 2019, p.12). Miller, Miller, and Stull (2007) found a need for counselor educators to continue to examine their own prejudices and discriminatory behaviors related to sexual orientation and gender identity and expression. Frank and Cannon (2010) posit that unless counselor educators increase awareness and are intentional in changing their assumptions, "they risk projecting their misconceptions and fears onto their students" (p. 21), contributing to the oppressive cycle of transmisia.

Salpietro, Ausloos, and Clark (2019) note specific challenges in treatment with trans* clients is related to lack of rigorous training that attends to family systems, intersectionality, and medical issues through transitioning, calling for a need for comprehensive, standardized, and thorough formal training (i.e., graduate school) and informal training through professional development opportunities. These findings are congruent with Shi and Doud (2017), who recommend PSCs specifically take advantage of professional development opportunities through conferences and workshops focusing on the LGBT population, in efforts to supplement formal educational curricula.

Bidell (2012) found low levels of skills among participants in community and school counseling students, indicating that graduate counseling programs are not providing rigorous training to work with clients of non-dominant sexual identities (LGBQ+), calling for specially designed multicultural and LGBTGEQIAP+ education and training for PSCs. These findings were congruent with other studies (Bidell, 2005; Day, 2008; Farmer & Welfare, 2013; Graham, 2012) which also found counselor

competence and comfort was low in working with LGB clients. However, a major gap in the literature exists as none of the aforementioned studies addressed counselor competence with trans* clients. O'Hara and colleagues (2013) found "essentially no difference in report of competence between new counselor trainees and advanced counselors, who have had much more formal coursework", stressing that counselor education programs are not appropriately training CITs to work with trans* clients (p. 248). Lloyd-Hazlett and Foster (2013) highlighted gaps in school counselor preparation programs and call for an increased in discourse about PSCs' "[roles] as advocates and social justice agents within comprehensive developmental school counseling frameworks" (p.335).

The Gay, Lesbian, and Straight Education Network (GLSEN) recently conducted a survey which found that about 81% of school mental health professionals received "little to no competency training in their graduate programs related to working with [trans*] populations" (GLSEN, ASCA, ACSSW, & SSWAA, 2019, p.xviii), and about 74% of participants rated their graduate training programs as "fair or poor" in preparing them for work with trans* youth in schools (GLSEN et al., 2019, p. xviii). GLSEN and other professional organizations (2019) also found that about 22% of school mental health professionals feel not at all confident, and 43% feel not very confident in addressing the health and mental health needs of trans* students, specifically about medical care (GLSEN et al., 2019). There is clearly a need for increased attention to trans*-issues by counselor educators in formal educational programs, infused throughout curricula, and an increase in trans*-related professional development offerings.

Professional School Counselors

Professional School Counselors (PSCs) are in a unique position to provide safety and support for trans* students, promote change within systems, and act as social justice advocates within the school (Bemak & Chung, 2008). The American School Counselor Association (ASCA), the professional association for school counselors, mandates that PSCs "promote affirmation, respect and equal opportunity for all individuals regardless of sexual orientation, gender identity, or gender expression… and promote awareness of and education on issues related to LGBT students" (ASCA, 2016, p. 37).

The ASCA National Model (2018) provides a framework for a comprehensive school counseling program, promoting student achievement, and is preventative in nature; with PSCs providing a range of services at various levels. PSCs provide direct student services through core curriculum, individual student planning, and responsive services; as well as indirect services, through referrals, consultation and collaboration with stakeholders, teachers, and families (ASCA, 2018). As previously mentioned, an important aspect of a school counselors' role is implementing a preventative, systemic comprehensive school counseling program that addresses the academic, career, and social/emotional needs of students. PSCs implement Multitiered Systems of Support (MTSS), including response to intervention (RTI) and positive behavioral interventions and supports ([PBIS], ASCA, 2018). RTI is a multi-tier approach to identifying and supporting students at various levels of learning and behavioral needs: Tier 1, Universal Core Instructional Interventions; Tier 2, Strategic Interventions for Students at Some Risk; and Tier 3, Intensive Interventions for Students at High Risk (Radd, 2018). PBIS is a preventative, systems-based approach used to achieve changes in the school Radd, 2018), which helps establish social, cultural and behaviors supports for the best learning

environments for *all* students. Working with trans* students, PSCs should provide services through the MTSS lens (ASCA, 2018), in an indirect way, through collaboration, supporting school administration and staff (ie., trainings, meetings, workshops), and also directly intervening to provide direct student services (ie., individual counseling, small counseling groups, working with families). Of importance to note is the PSCs role in collaboratively working "with other educators to remove systemic barriers for all students…" (ASCA, 2018, p.46).

Additionally, the ASCA *Ethical Standards* (2016) mandate that PSCs "have a primary obligation to the students, who are to be treated with dignity and respect as unique individuals" (Ethical Code A.1.a, p. 1). ASCA (2016) adopted a position that PSCs recognize "the responsibility for determining a student's gender identity rests with the student rather than outside confirmation from medical practitioners, mental health professionals, or documentation of legal changes" (ASCA, 2016, p. 64). This is an important concept for PSCs as advocates and agents of change in school systems.

In 2019, ASCA released the *School Counselor Professional Standards & Competencies*, which mandate that part of a PSCs' professional foundation is to "demonstrate basic knowledge and respect of differences in customs, communications, traditions, values, and other traits among students based on race, religion, ethnicity, nationality, sexual orientation, gender identity, physical or intellectual ability and other factors" (ASCA, 2019, p. 3). Through the ASCA National Model (2012), ASCA Ethical Standards (2016), and ASCA School Counselor Professional Standards and Competencies (2019), it is clear that aspirationally and pragmatically, PSCs should possess knowledge and skills in working with and advocating for trans* youth through a

range of services at various levels, and in coordination with other stakeholders in schools, all while respecting students' autonomy and authenticity (ASCA, 2016; ASCA, 2019; Bemak & Chung, 2008).

Best Practices in Working with Trans* Students

Within the past ten years, researchers have developed conceptual best practices for working with LGBTQ youth in schools. Gonzalez and McNulty (2010) promote four strategies for maximizing advocacy within the school system: (a) effective messaging, (b) student empowerment, (c) educating school personnel, and (d) legislative and community collaboration. Henry and Grubbs (2016) posit several best practices for PSCs in working with trans* students in schools, including awareness of one's own attitude, knowledge of law and language, promoting inclusive policies and procedures, increasing visibility of trans* students, advocating for inclusive curriculum, promoting inclusive co-curricular activities, educating staff, and infusing trans* issues into school-wide programming. Asplund and Ordway (2018) posit the SCEARE model as a tool for PSCs to "effectively conceptualize their interventions" (p.20). Using this model, PSCs (SC) scaffold interventions through education (E), affirmation by adults (A), responsive LGBTQ-focused bullying prevention programs (R), and student empowerment (E; Asplund & Orway, 2018). Bemak and Chung (2008) challenge counselors to move beyond the "[nice counselor syndrome]" to become social justice advocates and change agents in schools. Cooper, Dollarhide, Radliff, and Gibbs (2014) encourage hosting training focused on ally development within schools, going beyond LGBTQ terminology to foster "personal awareness, knowledge, skills, and actions related to development as an LGBTQ ally" (p.350). Goodrich, Harper, Luke, and Singh (2013) highlight the importance of

collaboration with stakeholders to promote systemic change, as well as advocacy through effective messaging, coalition-building, and youth empowerment and activism. Overall, current research demonstrates a shift in best practices to include deeper self-reflection of PSCs in their work with trans* youth (Cooper et al., 2014; Henry & Grubbs, 2016), empowering and fostering self-advocacy among trans* youth (Asplund & Orway, 2018; Gonzalez & McNulty, 2010; Goodrich et al., 2013), and through social justice and intentional advocacy efforts that address systemic change (Asplund & Orway, 2018; Cooper et al., 2014; Gonzalez & McNulty, 2010; Goodrich et al., 2013; Henry & Grubbs, 2016).

Although researchers and professional counseling organizations (ACA, ALGBTIC, ASCA) offer a framework for PSCs working with LGBTGEQIAP+ students (Asplund & Orway, 2018; Bemak & Chung, 2008; Cooper et al., 2014; Gonzalez & McNulty, 2010; Goodrich et al., 2013; Henry & Grubbs, 2016), studies indicate that professionals in schools are still not prepared to work with LGBTGEQIAP+ students, and that PSCs are less competent to work with LGBTGEQIAP+ populations compared with clinical counselors and other mental health professionals (Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; Mahdi et al., 2014; Shi & Doud, 2017). This is a particularly alarming as an increasing amount of younger people identify as trans* and will require a supportive school environment (James et al., 2016; National LGBTQ Task Force, 2019; Price et al., 2019; USCB, 2018).

While ASCA (2016) dictates that PSCs "provide [parents] with accurate, comprehensive, and relevant information…as is appropriate and consistent with ethical and legal responsibilities to the student and parent" (p. 6), research shows PSCs are

uncomfortable working with families because of issues related to privacy, confidentiality, safety and personal discomfort (Goodrich et al., 2013). It is important to note that parental rejection and isolation from peers contributes greatly to mood disorders, an increase in mental health issues, and increased suicidality (Oranksy & Steever, 2018), while trans* students who reported having support by their parents felt less burdensome, experienced overall higher life satisfaction, and decreased suicidality (Simons, Schrager, Clark, Bezler, & Olson, 2013). Therefore, an essential component of PSCs' working with trans* students is attending to family needs, through fostering ally development, psychoeducation, and assisting with navigating resources and barriers (Harper & Singh, 2014).

Summary

In sum, trans* issues continue to gain more visibility and trans* people increasingly need affirmative care in communities and schools. Researchers continue to examine experiences of LGBTGEQIAP+ persons, without giving specific attention to trans* persons, especially trans* youth (Clark & Serovich, 1997; Frieze & Dittrich, 2013; Goodrich, Catena, & Sands et al., 2015; Greenspan et al.,2017; Hartwell et al., 2012; O'Brien, 2107; Phillips, Ingram, Smith, & Mindes, 2003; Singh & Shelton, 2011). While there have been numerous standards published (ALGBTIC, 2009, 2013; ASCA, 2016, 2019; Coleman et al., 2011), much of the information is focused on trans* adult populations, or on LGBTGEQIAP+ persons as a whole. With the high prevalence of discrimination, abuse and assault against trans* youth, particularly in the school-setting, it is imperative trans* students have supportive adults in their lives as protective factors, including PSCs. While PSCs are tasked with working with trans* students, researchers

note a lack of self-perceived competence, inability to work with families and others in the school system, and are uncomfortable and unfamiliar with trans* issues (Bidell, 2012; Farmer et al., 2013; Graham et al., 2012; Mahdi et al., 2014; Shi & Doud, 2017). Therefore, the proposed study must be conducted to further explore how PSCs can best meet the needs of trans* students.

Chapter 3

Method

The author employed a cross-sectional survey design to a sample (*N*=389) of PSCs in the United States, working in a K-12 public school setting. Cross-sectional survey research allows for researchers to collect data and generate research results in a timely manner, based on data collection from one-point in time (Sheperis, Young, & Daniels, 2017). This chapter provides an overview of the research design, specific sampling procedures, instrumentation used for measurement, and data collection, data cleaning, and data analysis procedures.

Research Design

The present study is a non-experimental correlational survey design, as there is no manipulation of variables, the researcher intends to examine the relationship between two or more variables, and at least two scores for each individual group are collected (Lapan & Quartaroli, 2009). The study can be classified as cross-sectional (by the time dimension) and explanatory (by the objective dimension), as data were collected at one point in time and participants were analyzed as a single group, that is, and no separate control or treatment groups were used. This type of design is often used to explain how a phenomenon works (Johnson, 2001). The variables of the study include four categorical, independent variables and one continuous dependent variable. The independent variables are: (a) post-graduate training on trans* issues, (b) if the PSC has worked with trans* students during professional tenure, (c) personally knowing someone who is trans* outside of the school setting, and (d) PSC gender identity. Post-graduate training refers to whether or not PSCs have participated in educational opportunities after graduate school,

such as workshops or panels at conferences, professional development, continuing education, and in-service opportunities offered by schools or other professional organizations (Farmer & Welfare, 2013; GLSEN, ASCA, ACSSW, & SSWAA, 2019). The second independent variable is conceptualized as whether or not a PSC has worked with trans* students in their professional tenure (Shi & Doud, 2017). With this variable, there is an assumption that the student has self-identified as trans* and the PSC is aware of the students' gender identity during the time in which they are working. The third variable refers to whether or not a PSC personally knows someone who is trans*, outside of clinical or academic work-settings (O'Hara et al., 2013). In being inclusive of all gender identities, PSC gender identity was collected as a write-in option as opposed to categorizing, using forced-choice responses (Cohn, 2015; Hughes, Camden, & Yangchen, 2016; USCB, 2019). These variables were assessed via a demographic questionnaire (See Appendix C). The continuous dependent variable, school counselor self-perceived competence, was measured as a scaled score on the 29-item Gender Identity Counselor Competency Scale (GICCS), which is a revised version of the Sexual Orientation Counselor Competency Scale (SOCCS, Bidell, 2005; O'Hara et al., 2013).

The researcher utilized IBM Statistical Package for the Social Sciences (SPSS 26) for data analysis. To best answer the research questions, the researcher used a series of standard multiple regression analyses, which determine "the existence of a relationships and the extent to which variables are related, including statistical significance" (Sheperis, Young, & Daniels, 2017, p.131). While multiple regression analysis can be used in prediction studies, it can also be used to determine how much of the variation in a dependent variable is explained by the independent variables (Johnson, 2001; Laerd

Statistics, 2019). In order to run a multiple regression analysis, the researcher considered the assumptions of regression: a) normality (normal distribution of residuals), b) independence of residuals, c) homoscedasticity (equal error variances), and d) linearity (DeCoster, 2007; Laerd Statistics, 2019; Sheperis, Young, & Daniels, 2017).

Participants

Participants in this study (*N*=389) identified as PSCs who hold a valid school counseling license, and work in a public-school setting, from kindergarten through 12th grade, in the United States. The researcher was intentional in selecting participants who were licensed PSCs based on existing research that indicates school counselors are less competent to work with LGBT populations compared to other types of professional counselors and school-based mental health professionals (Bidell, 2012; Farmer et al., 2013; Mahdi et al., 2014). The study did not target school-based clinical mental health counselors or clinical counselors, who vary in identity and professional practice. Participants' ages ranged from 24 to 66 years old (*M* =40.10 , *SD*= 9.81). Regarding gender, 368 participants identified as cisgender women (94.6%), 17 participants identified as cisgender men (4.4%), one participant identified as non-binary/trans*/genderqueer (0.3%), one participant identified as mostly-female (0.3%), one participant identified as trans*masculine/man (0.3%), and one participant identified as agender (0.3%). Ethnoculturally, 337 participants identified as White (86.6%), 16 participants identified as Hispanic, Latino, or of Spanish origin (4.1%), 15 participants identified as Black or African American (3.9%), nine participants identified as Multiracial (2.3%), seven participants identified as Asian or Asian American (1.8%), two participants identified as American Indian or Alaska Native (0.5%), two participants

identified as Middle Eastern or North African (0.5%), and one participant indicated they prefer not to answer (0.3%). Participant years working as a PSC ranged from less than one year to 34 years (M = 8.70, SD = 7.37). Regarding geographic location, 135 participants indicated they worked in the Midwest (34.7%), 126 participants indicated they worked in the South (32.4%), 72 participants indicated they worked in the West (18.5%), and 56 participants indicated they worked in the Northeast (14.4%). When asked about school setting, 207 participants indicated they worked in a Highschool (53.2%), 150 participants indicated they worked in an Elementary School setting (38.6%), and 90 participants indicated they worked in a Middle School Setting (23.1%). Of the total sample (N= 389), 297 participants (76.3%) indicated they had worked with trans* students in schools in their professional tenure. 193 participants (49.6%) indicated they engaged in some type of post-graduate training on trans* issues or populations. Finally, 93 participants (23.9%) indicated that they had personal relationships with trans* folx outside of their professional role.

Sampling Procedures

According to The Bureau of Labor Statistics (2017), there are 133,780 PSCs working in elementary and secondary schools in the United States. The American School Counselor Association (ASCA), the leading association of PSCs, hosts about 36,000 professional members who identify as administrators or PSCs (ASCA, 2019). The researcher used 36,000 participants as the sampling frame, "the group of individuals that can be selected from the target population" (i.e. PSCs; Martinez-Mesa et al., 2016). With an anticipated medium effect size of 0.15 (Cohen, 1988), a desired statistical power level of 0.95, and desired probability level of 0.05 (Israel, 2013), the researcher determined an

appropriate minimum sample size for the proposed study is 120 PSCs, which was confirmed through the use of two statistical calculators (G*Power, 2019; Soper, 2019).

A simple random sample selection process was used in this study, decreasing *selection* as a threat to internal validity (probability sampling; Creswell, 2013; Elfil & Negida, 2017). While ASCA does not share member email addresses, per the CAN-SPAM Act of the Federal Trade Commission (FTC, 2019; A. Hickman, personal communication, August 16, 2019), *ASCA Scene*, ASCA's online community of over 35,000 members, allows for connecting with members and eliciting research participants through posting on message boards (ASCA, 2019). Additionally, *ASCA Aspects*, an electronic newsletter is emailed monthly (around the 15th of each month) to around 36,000 ASCA members who elected this option (ASCA, 2019; A. Hickman, personal communication, August 16, 2019). In order to reach saturation of sample size, the researcher first posted the participant recruitment letter (Appendix A) in *ASCA Scene,* in the Open Forum section in early December 2019, and the survey closed late January 2020. The recruitment letter contained researcher details and contact information, the topic of research, IRB approval information, participant inclusion criteria, and language promoting the incentive of 100 randomly drawn $10 Amazon E-Gift Cards (if selected, one per participant, sent within one month of completing the survey) upon successful completion of the survey. Additionally, the letter contained the link to the Qualtrics survey, which contained an informed consent document, a demographic questionnaire, and the GICCS (Bidell, 2012; O'Hara, 2013).

Additionally, the researcher submitted the participant recruitment letter to Angela Hickman, Director of Research Media, who posted the call within *ASCA Aspects.* The

section of the e-newsletter stated “Participate in Research”, with a short description of the purpose of the research study; researcher details, including name, status of doctoral candidacy, and University; and a direct hyperlink to the Qualtrics survey (ASCA, 2019). Participants had an option to enter their email address at the end of the survey for the chance to receive a $10 Amazon E-Gift Card. The author posted a reminder letter on the ASCA Scene website two weeks after the initial post. A final reminder letter was posted four weeks after the initial post. Data were collected in a one-month period of time.

Instrumentation

Participants who clicked on the link either through *ASCA Scene* or *ASCA Aspects* were directed to a survey which contained three components, respectively: (a) an informed consent document, (b) a demographic questionnaire, and (c) the GICCS (Bidell, 2012; O’Hara, 2013). The informed consent document was followed by the demographic questionnaire, then the GICCS. All participants receive the same instruments throughout the study, in the same order, reducing *testing* as a threat to internal validity (Creswell, 2013). The informed consent document outlined the study details, contained the researchers’ contact information, as well as provided assurances of ethical principles that will be adhered to throughout the research process. The informed consent document also outlined the assurance that researchers made every effort to protect privacy and confidentiality, as well as inform participants about the potential risks and benefits of the participation in the study. Information was stored on a secure, password-protected folder in the possession of the principal investigator, and participants had the right to withdraw from the research at any time. A copy of the informed consent document used can be found in Appendix B.

Demographic questionnaire. Participants completed a questionnaire to gather information regarding participants' age, gender identity, racial-ethnic identity, years working as a licensed school counselor, the region in which they currently practice, and grade levels in which the participants work. The questionnaire can be found in Appendix C.

PSC Gender Identity. Researchers recommend that special attention is given within a category of interest (i.e., *gender identity*), to historically marginalized groups, encouraging counselor-researchers to view all samples "in terms of their particularity and to attend to diversity within samples" (Cole, 2009, p.176). The researcher was intentional in using PSC gender identity demographic factors in data analysis, attending to diversity among PSC gender, as research indicates there may be relationships between counselor gender identity, privilege and oppression and multicultural counselor competence (Cole, 2009). While the researcher found no studies exploring relationships between PSC gender identity and PSC awareness towards non-dominant gender identities, literature demonstrates that there is a relationship between sexual identities (both dominant and non-dominant) and awareness of non-dominant sexual identities; for example, gay women have more favorable attitudes towards gay people in general, while gay men hold unfavorable attitudes towards other gay men, but hold more positive attitudes towards lesbians (Anderson, 2009; Cuddy & Fiske, 2004). Other researchers have found relationships between gender role conflicts (specifically men) and attitudes towards counseling and counselors (Gillen, 2012; Landes, Burton, King, & Sullivan, 2013; Phoenix, 2014; Wisch & Mahalik, 1999; Wisch, Mahalik, Hayes, & Nutt, 2004). Additionally, the researcher is interested in exploring the gender as a variable, as

counselors providing services to students who share similar life histories create unique challenges and opportunities (Enns, 2012).

Professional experience with trans* students. O'Hara and colleagues (2013) found no significance on scores of counseling competence between counseling students who completed practicum or internship and those who did not, however the present study differs in that variables relate to PSCs who have *already* graduated, reflecting on their professional tenure, and if those experiences provided opportunities to work with trans* students. Participants answered dichotomously (yes or no) to: *Have you worked with self-identified trans* students during your work as a PSC?*

Post-graduate training addressing trans* issues. Researchers note that graduate programs in counselor education are not adequately preparing counseling students, specifically school counseling students, to work with trans* students (Bidell, 2012; Day, 2008; Farmer & Welfare, 2013; Frank & Cannon, 2010; GLSEN, ASCA, ACSSW, & SSWAA, 2019; Graham, 2012; O'Hara et. al., 2013), and that much of the awareness, knowledge, and skills gained in working with this population is a result of counselors self-seeking professional trainings, education, and workshops that are focused on trans* issues and students (Salpietro, Ausloos, & Clark, 2019; Lloyd-Hazlett & Foster, 2013; Shi & Doud, 2107). Specifically, the demographic questionnaire in this study asked participants to answer yes or no to: *Have you received post-graduate training addressing trans* issues?* (This includes any training or education that you received after your graduate program that was/is focused on trans* issues/persons).

Personal relationships with trans* people. In their formative study, O'Hara and colleagues (2013) found that participants identified informal sources as imperative in

counseling students accessing trans*-affirming knowledge and skills in working with trans* students, such as "exposure to or personally knowing someone who [is trans*]" (p. 246). Research supports the concept that increasing affirming attitudes and mitigating negative attitudes and beliefs towards trans* individuals can be accomplished by exposure to trans* persons, and intentionally engaging in fostering personal relationships with trans* people, both professionally, but also personally (Henry & Grubbs, 2016; Salpietro et al., 2019). GLSEN (2019) recommends future research should "examine the specific influence of knowing LGBTQ people at school versus in personal lives" (GLSEN et al., 2019, p. 42). Therefore, the present study asked participants to answer yes or no to: *Do you personally know someone who identifies as trans* that is not a student in the K-12 school setting?*

Gender Identity Counselor Competency Scale. The proposed study utilized the Gender Identity Counselor Competency Scale (GICCS), a revised version of the Sexual Orientation Counselor Competency Scale (SOCCS), as this is the instrument best suited for intended measurement of self-perceived competence (Bidell, 2012; O'Hara et al., 2013).

The creation of the SOCCS (Bidell, 2005) is a result of the absence of LGB "theory-based research and instrumentation" by providing a tool to use in counselor education programs, supervision and training, assessing a counselors competency in working with lesbian, gay, and bisexual (LGB) clients (Bidell, 2005, p. 276). Bidell (2005) developed the instrument based on Sue and colleagues (1992) research of multicultural counseling competencies, with the domains of attitudinal awareness, knowledge, and skills. In his instrument development, Bidell (2005) noted the limitation

in that the SOCCS reflects the construct of sexual orientation, and not gender, "requiring different competencies for counselors" (Bidell, 2005, p. 268). Since its' inception, the SOCCS (2005) has been used in examining affirmative counseling assessments (Bidell, 2012), examining counselor education multicultural and diversity courses (Bidell, 2013, 2014), counselor training (Ober, Granello, & Wheaton, 2012; Rutter, Estrada, Ferguson, & Diggs, 2008), and counselor competence with LGB persons in a variety of settings (Bidell, 2012; Farmer et al., 2013; Grove, 2009; Hall, McDougald, & Kresica, 2013).

Bidell (2005) reported the Cronbach's alpha of .90, with subscale scores for internal consistency of .91 for the skills subscale, .88 for the awareness subscale, and .71 for the knowledge subscale (Bidell, 2005 & 2013). Test-retest reliability for the overall instrument was found to be .84, .83 for the skills subscale, .85 for the awareness subscale, and .84 for the knowledge subscale (Bidell, 2005). Researchers consider the instrument has "adequate psychometric properties" (Graham, Carney & Kluck, 2012, p.6). Criterion validity of the initial instrument was established by examining level of education and participant sexual orientation on SOCCS scores (Cor, 2016; Graham, Carney, & Luck, 2012; O'Hara et al., 2013. Convergent validity was supported by comparing the SOCCS subscales with established instruments: the Awareness subscale was compared with the Attitudes Toward Lesbians and Gay Men Scale (ATLG; Herek, 1998); the knowledge subscale was compared with the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), and the skills subscale was compared with the Counselor Self-Efficacy Scale (CSES; Melchert, Hays, Wiljanen, & Kolocek, 1996; [Ali, Lambie, & Bloom, 2017; Bidell, 2005, 2012; Cor, 2016; Farmer et al., 2013; O'Hara et al., 2013]). Discriminant validity was established by comparing scores on the SOCCS

subscales with the mean social desirability scores using the Marlowe-Crowne Social Desirability Scale (MC-SDS; Crowne & Marlowe, 1960), indicating "weak associations" (Bidell, 2005, p.275). Other studies have examined the factor structure of the SOCCS (Carlson, McGeorge, & Toomey, 2013), but modifications were made (7-point scale was adapted to 6-point scale), making it challenging to compare results.

The GICCS is a 29-item self-report assessment on a seven-point Likert scale (where one is not at all true and seven is totally true). Examples of questions include: "I have received adequate clinical training and supervision to counsel transgender clients" and "The lifestyle of a transgender client is unnatural or immoral" (O'Hara et al., 2013, p. 242). This instrument allowed researchers to examine levels of PSC perceived competence, which is the dependent variable in this proposed study. Higher scores on the GICCS will be indicative of higher levels of self-perceived competence in working with trans* students. A copy of the GICCS can be found in Appendix D.

Awareness Subscale. This subscale of the GICCS (2013) consists of 10 items focused on counselors attitudinal awareness and prejudice about trans* clients, including statements like "It would be best if my clients viewed a [cisgender] lifestyle as ideal " and "I think that my clients should accept some degree of conformity to traditional [gender] values" (Bidell, 2005, p.273). Cronbach's alpha for the Awareness subscale has been reported as 0.88 (Bidell, 2005).

Knowledge Subscale. This subscale of the GICCS (2013) consists of 8 items focused on counselors experiences and skills with trans* clients, including statements like "I am aware that counselors frequently impose their values concerning [gender] upon [trans*] clients" and "I am aware of institutional barriers that may inhibit [trans*] clients from

using mental health services" (Bidell, 2005, p.273). Cronbach's alpha for the knowledge subscale was reported as 0.76 (Bidell, 2005).

Skills Subscale. This subscale of the GICCS (2013) consists of 11 items focused on counselors experiences and skills with trans* clients, including statements like "I have experience counseling [trans* male] clients" and "I have received adequate clinical training and supervision to counsel [trans*] clients" (Bidell, 2005, p.273). Cronbach's alpha for the skills subscale was reported as 0.91 (Bidell, 2005).

Data Collection Procedures

Upon approval as an exempt study from the Institutional Review Board (IRB) at the University of Toledo, the author began participant recruitment. Following procedures outlined by Mullen and Crowe (2017), the author posted a series of recruitment letters to PSCs through *ASCA Scene*; the post sent through *ASCA Aspects* was published once, as it is a monthly e-newsletter. Those PSCs who elected to participate in the study and clicked on the link were directed to the survey, hosted by Qualtrics (2019). Upon reaching sample size saturation after one month, and having successfully collected data, the researcher used a random number generator to select 100 participants to win $10 Amazon E-Gift Cards (one per participant, sent within one month of successful completion of the survey). The researcher used incentives to both increase potential sample size, as well as increase participant response rates (Dillman, 2000; as cited in Survey Monkey, 2009; Gendall, 2007; Hughes et al., 2016, Saldivar, 2012). To ensure privacy and anonymity, the researcher collected the emails for incentives as separate data, which were not connected to the study data, and these emails were deleted immediately after sending the incentive.

Data Analysis

Data Cleaning. The researcher first screened the data to ensure it was usable, reliable and valid to proceed with statistical analyses. Initially, 499 responses were recorded. Of those, 110 were incomplete or had missing data, yielding a total of 389 fully completed surveys. The researcher continued data cleaning by coding the demographic variable of gender identity 1 through 7: Cisgender Female (1), Cisgender Male (2), Nonbinary, Trans* and/or Genderqueer (3), and Agender (4). Racial-ethnic identities were coded 1 through 10: American Indian or Alaska Native (1), Asian or Asian American (2), Black or African American (3), Hispanic, Latino, or Spanish Origin (4), Middle Eastern or North African (5), Native Hawaiian or Other Pacific Islander (6), White (7), Some other race, ethnicity or origin (8), Prefer not to answer (9), and Multiracial Identity (10). PSC location was also coded, 1 through 5: Midwest (1), Northeast (2), South (3), West (4), Puerto Rico or other U.S. Territories (5), and Other (6). Last of the demographic variables, the researcher coded PSC School Level, 1 through 4: Elementary (1), Middle School (2), High School (3), and Other (4).

In addition, the researcher cleaned variables highlighting PSC professional and personal training and experiences with trans* persons. The first variable was dummy coded to reflect participants who had worked with trans* students (1) (n=297, 76.3%), and participants who indicated *not* working with trans* students (0) (n=92, 23.7%). The next variable, PSC post-graduate training, was dummy coded for use in data analyses, with those that indicated they engaged in post-graduate training (1) (n=193, 49.6%), and participants who indicated they did *not* engage in post-graduate training (0) (n=196, 50.4%).

The final variable was dummy coded to reflect participants who know someone who is trans* outside of the school setting (1) (*n*=93, 23.9%), and those participants who do *not* know someone who is trans* outside of the school setting (0) (*n*=296, 76.1%).

Per Bidell (2005), the researcher started by reverse scoring coded GICCS items 2, 10, 11, 15, 17, 21, 22, 23, 27, 28, and 29. The researcher then calculated the total GICCS mean score, a new variable, after calculating the GICCS total raw score. Then, the researcher calculated the attitudinal awareness subscale mean score, by using items 2, 10, 11, 15, 17, 21, 23, 27, 28, and 29; calculating the awareness raw score, and creating a new variable. The researcher calculated the skills subscale mean score by using items 1, 3, 4, 6, 7, 8, 12, 14, 18, 22, and 26, calculating the skills raw score and creating a new variable. The researcher then calculated the knowledge subscale mean score, using test items 5,9, 13, 16, 19, 20, 24 and 25; calculating the knowledge raw score, and creating a new variable.

Data Analysis. Post-data cleaning, the researcher entered all the data from the demographic questionnaire and the GICCS into SPSS 26. There are many assumptions to consider when conducting a multiple regression analysis, including a) two or more continuous or categorical independent variables, b) a continuous dependent variable, c) independence of residuals (or observations), d) linearity (both between dependent variable and each of the independent variables, and between the dependent variable and the independent variables as a whole), e) homoscedasticity, f) absence of multicollinearity, g) no significant outliers, and h) normally distributed residuals (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019; Williams, Grajales, & Kurkiewicz; Yoo et al., 2014).

The research variables met assumptions (a) and (b) in conducting multiple regressions (three categorical independent variables on a continuous dependent variable; Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019). In analyzing data in SPSS, independence of residuals was determined used the Durbin-Watson statistic (Krämer, 2011), which ranges in value from zero (0) to four (4), with a value near two (2) indicating *no correlation* between residuals (Laerd Statistics, 2019; Savin & White, 1977). Assumption (c) was met, as the Durbin-Watson value found was 1.46. Additionally, the author plotted a scatterplot using variables, as well as a partial regression with each of the independent variables and the dependent variable, and observed linear relationships, attending to the assumptions of linearity (d) and homoscedasticity ([e],Laerd Statistics, 2019; Osborne & Waters, 2002). Homoscedasticity (e), was also assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. To assess the absence of multicollinearity (f), the researcher considered the variance inflation factors (VIF) indicated in the coefficients table (Laerd Statistics, 2019; NCSS Statistical Software, n.d.; Williams, 2015). Hair and colleagues (2014) posit a VIF of greater than ten (10) may indicate a collinearity problem. The researcher found VIF values ranging from 1.01 to 1.05, indicating an absence of multicollinearity (f). Then, the researcher checked for unusual points (g): outliers, high leverage points, and highly influential points (Laerd Statistics, 2019). The researcher did identify a significant outlier (-3.10) in case number 133 by examining the range of standardized residuals ([-3.10 to 2.34], Osborne & Waters, 2002), which is outside the common cut-off range of 3 standard deviations (SD). The researcher then inspected the studentized deleted residual values, and found a value in

case number 133 (-3.15), which falls outside the common cut-off range of 3 SD. Additionally, the researcher determined two cases of problematic leverage values which were greater than the safe value of 0.2 (.36 and .23; Laerd Statistics, 2019). All cases that violated assumptions were filtered out and the standard multiple regression analysis was run again. This time, the data did not violate assumptions (a) through (g) (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019; Williams, Grajales, & Kurkiewicz; Yoo et al., 2014). Finally, normal distribution (h) was tested in SPSS, using "a histogram with superimposed normal curve and a P-P Plot" (Laerd Statistics, 2019, para. 16). The researcher observed approximately normally distributed standardized residuals using both methods. To determine if any cases are influential in the data, the researcher examined the Cook's Distance values, which ranged from .000 to .090. As there are no values above 1, there are no highly influential points (Cook & Weisberg, 1982).

As the author is interested in examining the relationship between several independent variables (four) and an outcome variable (dependent variable), with no control variables (covariates), a standard multiple regression analysis was used (Creswell, 2013). Multiple regression analyses were used to determine how much of the variation in the outcome variable is explained by all the independent variables, as well as to understand the "relative, unique contribution of each independent variable towards this total" (Laerd Statistics, 2019, para. 3).

In order to answer the first research question (the relationship between PSC factors on levels of school counselor self-perceived competency in working trans* students in schools as measured by total scores on the GICCS), the researcher used a

standard multiple regression analysis. (Grace-Martin, 2019; Lami, 2010; Sheperis, Young, & Daniels, 2017). To answer the second research question (the relationship between PSC factors on Awareness of PSCs in working with trans* students in schools) the researcher conducted another standard multiple regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019), using scores from only the *Awareness* subscale of the GICCS as the dependent variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). In order to answer the third research question (the relationship between PSC factors on knowledge of PSCs in working with trans* students in schools), the researcher conducted another regression standard regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019), using scores from only the *knowledge* subscale of the GICCS as the dependent variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). Finally, to answer the fourth research question (the relationship between PSC factors on skills of PSCs in working with trans* students in schools), the researcher conducted a standard multiple regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019), using scores from only the *skills* subscale of the GICCS as the dependent variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). Results of these analyses are discussed in the following section, Chapter 4.

Chapter 4

Results

In this chapter the author describes the research questions and hypotheses, characteristics of the sample, correlations of interest, and statistical analyses used in the present study.

Research Questions and Hypotheses

Research Question One

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the Gender Identity Counselor Competency Scale [GICCS; Bidell, 2012; O'Hara et al., 2013])?

H_{01}: There will be no statistically significant difference ($p>.05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_1: There will be a statistically significant difference ($p\leq.05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Research Question 2

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with trans* students in schools (as measured by scores on the Awareness subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_{02}: There will be no statistically significant difference ($p>.05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with trans* students in schools (as measured by scores on the Awareness subscale of the Gender Identity Counselor Competency Scale [Bidell, 2012; O'Hara et al., 2013]).

H_2: There will be a statistically significant difference ($p\leq.05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on awareness of PSCs in working with trans* students in schools (as measured by scores on the Awareness subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Research Question 3

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students in schools (as measured by scores on the Knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_{03}: There is no statistically significant difference ($p>.05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students

in schools (as measured by scores on the Knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_3: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on knowledge of PSCs in working with trans* students in schools (as measured by scores on the Knowledge subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Research Question 4

What is the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the Skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013])?

H_{04}: There is no statistically significant difference ($p > .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the Skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

H_4: There will be a statistically significant difference ($p \leq .05$) between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on skills of PSCs in working with trans* students in schools (as measured by scores on the Skills subscale of the GICCS [Bidell, 2012; O'Hara et al., 2013]).

Variables of Interest

PSC Gender Identity Competency

PSC Gender Identity Counselor Competency was measured through self-reported perceptions of awareness, knowledge, and skills when working with trans* students using the Gender Identity Counselor Competency Scale (GICCS), a revised version of the Sexual Orientation Counselor Competency Scale (*SOCCS*; Bidell, 2012; O'Hara et al., 2013). The internal consistency (Cronbach's alpha) of the original 29-item SOCCS was .90, with subscale scores for internal consistency of .91 for the skills subscale, .88 for the awareness subscale, and .71 for the knowledge subscale (Bidell, 2005 & 2013). In this study, the researcher found internal consistency of the overall GICCS (N = 389) was .87, a reliable value, with internal consistency for the awareness subscale was .89, a strong value, the Knowledge subscale was .72, a good value, and the Skills subscale was .85, a strong value (Taber, 2018). The GICCS uses a Likert-type 7-point scale (1 = Not At All True, 4 = Somewhat True, and 7 = Totally True), with higher scores indicating greater levels of sexual orientation counselor competency. Eleven items are negatively worded and are reverse scored. The GICCS scores found in this study are similar to scores used in the creation of the instrument, as well as previous studies (Bidell, 2005 & 2013; Farmer, 2011; Graham, Carney, & Kluck, 2012; O'Hara et al., 2013). The average subscale scores in this study were 6.31 (Awareness), 4.97 (Knowledge), and 3.46 (Skills), compared with another study (N=479), which found average subscale scores of 6.40 (Awareness), 4.20 (Knowledge), and 3.48 (Skills; Farmer, 2011). Descriptives of GICCS raw scores in the present sample are presented below in Table 1.

Table 1

GICCS Descriptives

	M	*SD*	Minimum	Maximum
GICCS Total	4.86	.75	2.17	6.52
GICCS Awareness	6.31	.85	1.50	7.00
GICCS Skills	3.46	1.22	1.00	6.27
GICCS Knowledge	4.97	.97	1.63	7.00

Notes. GICCS = Gender Identity Counselor Competency Scale (Bidell, 2005). GICCS scores are reported in raw form.

Demographic Variables

The following variables were measured via a demographic questionnaire that was part of the survey completed by participants (*N*=389): participants' age, gender identity, racial-ethnic identity, years working as a licensed school counselor, region in which they currently practice, and grade levels in which the participants work. After data cleaning, the categorical variables (gender identity, racial-ethnic identity, region of practice, and grade levels of practice) were dummy coded for the regression analysis.

Correlations Between Variables of Interest

Prior to the regression analysis, the researcher examined correlations between the variables: PSC Gender Identity (CisFemale, CisMale, Trans*, Agender), having worked with trans* students, post-graduate training experiences, personally knowing someone who is trans*, the transformed GICCS Awareness subscale, the GICCS Skills subscale, the GICCS Knowledge subscale, and the GICCS Total score. Correlations of variables of interest are found in Table 2, while a table including all variables used in the study is

found in Appendix E. There were multiple significant correlations as determined by Pearson product moment correlations (*r*). The GICCS total score was significantly correlated with the Awareness transformed subscale (*r*=-.65, *p*< .001), the Skills subscale (*r*=.83, *p*< .001), and the Knowledge subscale (*r*=.66, *p*< .001). The transformed Awareness subscale was significantly correlated with the Skills subscale (*r*=-.26, *p*< .001) and the Knowledge subscale (*r*=.30, *p*< .001). The Knowledge subscale was also significantly correlated with the Skills subscale (*r*=.30, *p*< .001). In examining demographic factors, CisFemale Gender Identity (GI) was significantly correlated with CisMale GI (*r*=-.90, *p*< .001), Trans* GI (*r*=-.37 *p*< .001), and Agender GI (*r*=-.21, *p*< .001). Additionally, CisFemale GI was significantly correlated with having worked with trans* students (*r*=-.12, *p*= .036), as well as the GICCS Total score (*r*=-.14, *p*=.005), the Skills subscale (*r*=-.14, *p*=.005), and the Knowledge subscale (*r*=-.15, *p*=.003). CisMale GI was significantly correlated with the GICCS Total score (*r*=.11, *p*=.038), the Skills subscale (*r*=.12, *p*=.017), and the Knowledge subscale (*r*=.11, *p*=.003). Trans* GI was significantly correlated with personally knowing someone who is trans* (*r*=.12, *p*=.002), as well as with the GICCS Total score (*r*=.12, *p*=.034). Having worked with trans* students was significantly correlated with the GICCS Total score (*r*=.41, *p*<.001), the Skills subscale (*r*=.55, *p*<.001), and the transformed Awareness subscale (*r*=-.11, *p*=.032). Post-graduate training was significantly correlated with many variables, including personally knowing someone who is trans* (*r*=.14, *p*=.005), with the GICCS Total scores (*r*=.36, *p*<.001), the Skills subscale (*r*=.41, *p*<.001), the Knowledge subscale (*r*=.19, *p*<.001), and the transformed Awareness subscale (*r*=-.10, *p*=.040). Last, personally knowing someone who is trans* was significantly correlated with the GICCS

Total score (r=.35, p<.001), the Skills subscale (r=.29, p<.001), the Knowledge subscale (r=.25, p<.001), and the transformed Awareness subscale (r=-.22, p<.001).

Table 2

Correlation Table for Variables of Interest

	1	2	3	4	5	6	7	8	9	10	11
1. CisFemale	--	-.895**	-.369**	-.213**	-.106*	-.013	-.079	-.143**	-.143**	-.152**	.001
2. CisMale	--	--	-.019	-.011	.089	.039	-.002	.105*	.121*	.112*	.021
3. Trans*	--	--	--	-.004	.049	-.029	.157**	.108*	.096	.090	-.041
4. Agender	--	--	--	--	.028	-.050	.091	.026	-.015	.074	-.021
5. Trans* Client	--	--	--	--	--	.080	.071	.407**	.545**	.065	-.109*
6. Training	--	--	--	--	--	--	.143**	.361**	.407**	.188**	-.104*
7. Personal	--	--	--	--	--	--	--	.346**	.286**	.247**	-.218**
8. GICCS Total	--	--	--	--	--	--	--	--	.827**	.655**	-.647**
9. Skills	--	--	--	--	--	--	--	--	--	.303**	-.255**
10. Knowledge	--	--	--	--	--	--	--	--	--	--	-.310**
11. Awareness+	--	--	--	--	--	--	--	--	--	--	--

Notes. GICCS = Gender Identity Competency Scale (Bidell, 2005). *= p<.05; **=p< .001. += a transformed variable

Research Question One

In order to examine the relationship between PSC factors on levels of school counselor self-perceived competency in working trans* students in schools, the researcher used a standard multiple regression analysis (Grace-Martin, 2019; Lami, 2010; Sheperis, Young, & Daniels, 2017). First, the assumptions of regression were tested. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.019. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by VIF values (1.01 – 1.05). The

researcher identified a studentized deleted residual greater than ±3 standard deviations (-3.153), as well as a standardized residual (-3.096) violation of normality (Laerd Statistics, 2019). The researcher also examined the ordered leverage values of the data, and determined there were (2) cases of leverage values greater than 0.2 (.23 and .36), which is the "safe value" (0.4), indicating violations (Laerd Statistics, 2019). The researcher found no values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot. The researcher filtered case numbers one (1), two (2), and 389 prior to the regression analysis.

The GICCS Awareness subscale violated the assumption of normality, in that its' skewness was -1.89 and had a Kurtosis value of 3.98. Kurtosis is generally a measure of outliers present in the distribution (Kim, 2013). In observing a histogram of the Awareness subscale, the researcher determined this variables' distribution had Leptokurtic Kurtosis, that is the distribution is longer, and the peak is high and sharp (Kim, 2013). The researcher transformed the strongly negatively skewed data by locating the largest score in the Awareness subscale data set (7), adding 1 to its' value (8), and applying a "reflect and logarithmic" transformation (Kim, 2013; Laerd Statistics, 2019). After this step, the researcher again calculated Skewness and Kurtosis in SPSS (v.26), which were 0.949 and .189, respectively, transforming this variable from non-normally distributed data to normally distributed data.

After meeting all assumptions and transforming variables, the researcher ran the regression analysis ($N = 387$). No violations were found. R^2 for the overall model was 35.2%, with an adjusted R^2 of 34.1%, a small to moderate size according to Cohen (1988). Table 3 summarizes the change statistics for regression one. PSC factors (gender,

post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) significantly predicted levels of school counselor self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS [Bidell, 2012; O'Hara et al., 2013]), $F(6, 381) = 34.430$, $p < .001$. It is important to discern the amount of weight given to each variable in the regression equation by examining beta weights (β), and by examining structure coefficients, which inform researchers as to the bivariate relationship of the variable of interest, without the effects of the other variables (DeCoster, 2007). Having worked with Trans* Students received the strongest weight in the model (β=.35), followed by Post-Graduate Training (β=.29), followed by Personally knowing someone who is trans* (β=.27). The variable with the most weight, Having worked with Trans* Students, had a structure coefficient (r_s) of .67, and r_s^2 was 45.2%. That means, of the 35.2% effect (R^2), this variable accounts for 45.2% of the explained variance by itself. A summary of regression coefficients and standard errors can be found in Table 4 (below).

Table 3

Summary of Multiple Regression One (N=387)

				Change Statistics					
Model	*R*	R^2	*Adj* R^2	Std. Error	ΔR^2	ΔF	df1	df2	Sig ΔF
1	.593	.352	.341	.59647	.352	34.430	6	381	.000

Notes. Model 1 includes all variables (gender, post-graduate training, PSC work with trans* students, and PSC personal relationships with someone who is trans*) and total GICCS scores.

Table 4

Summary of Multiple Regression One Analysis Coefficients (N=387)

	B	SE_β	β
(Constant)	4.064	.068	--
CisMale GI	.231	.149	.064
Trans GI	.492	.351	.059
Agender GI	.106	.601	.007
Trans Students	.605	.0725	.349
Training	.430	.062	.293
Personal	.466	.073	.271

Notes. $p<0.5$, *B* = unstandardized regression coefficient; SE_β = Standard error of the coefficient; β = standardized coefficient

Research Question Two

To examine the relationship between PSC factors on awareness of PSCs in working with trans* students in schools, the researcher conducted another standard multiple regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics,

2019), using transformed scores from only the Awareness subscale of the GICCS as the dependent variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). Again, in this model, several assumptions were tested. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.319. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by VIF values (M=1.02). A violation of normality was found, as the researcher identified two (2) studentized deleted residual greater than ±3 standard deviations (3.38 and 3.34). These cases were filtered and the regression analysis was conducted again (N = 387). Table 5 summarizes the change statistics for regression two. R^2 for the overall model was 5.8%, with an adjusted R^2 of 6.2%, a very small effect size (Cohen, 1988). PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) significantly predicted awareness of PSC self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS Awareness subscale [Bidell, 2012; O'Hara et al., 2013]), $F(6,380) = 3.873$, $p=.001$. The Awareness subscale of the GICCS examines a PSC's self-awareness of anti-trans* biases and stigmatization (Bidell, 2005). Personally knowing someone who is trans* was the only significant predictor in this model. The researcher examined the regression coefficients and corresponding data (β=-.20, r_s=-0.90, r_s^2 =80%). Of the 5.8% effect (R^2), personally knowing someone who is trans* accounts for 80% of the explained variance by itself. A summary of regression coefficients and standard errors can be found in Table 6 (below).

Table 5

Summary of Multiple Regression Two (N=387)

				Change Statistics					
Model	*R*	R^2	*Adj* R^2	Std. Error	ΔR^2	ΔF	df1	df2	Sig ΔF
2	.240	.058	.043	.38349	.058	3.873	6	380	.001

Notes. Model 2 includes all variables (gender, post-graduate training, PSC work with trans* students, and PSC personal relationships with someone who is trans*) and scores on the transformed Awareness subscale of the GICCS.

Table 6

Summary of Multiple Regression Two Analysis Coefficients (N=387)

	B	SE_β	β
(Constant)	.547	.044	--
CisMale GI	.067	.096	.035
Trans GI	-.027	.226	-.006
Agender GI	-.024	.387	-.003
Trans Students	-.078	.046	-.085
Training	-.044	.040	-.057
Personal	-.183	.047	-.199

Notes. $p<0.5$, *B* = unstandardized regression coefficient; SE_β = Standard error of the coefficient; β = standardized coefficient

Research Question Three

To examine the relationship between PSC factors on knowledge of PSCs in working with trans* students in schools, the researcher conducted another regression standard regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019), using scores from only the knowledge subscale of the GICCS as the dependent

variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). Again, in this model, several assumptions were tested. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.335. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by VIF values (M=1.02). The researcher identified three (3) studentized deleted residuals greater than ±3 standard deviations (-3.02, -3.13, -3.35), and filtered out these cases prior to re-running the regression analysis. The researcher examined the ordered leverage values of the data, and determined there were no leverage values greater than 0.2, which is the "safe value". The researcher found no values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot. Table seven (7) summarizes the change statistics for regression three (N = 386). R^2 for the overall model was 10.3%, with an adjusted R^2 of 8.9%, a small effect size (Cohen, 1988). PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) significantly predicted knowledge of PSC self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS Knowledge subscale [Bidell, 2012; O'Hara et al., 2013]), $F(6, 379) = 7.257$, $p < .001$. The Knowledge subscale of the GICCS measures PSC knowledge of the unique psychosocial issues experienced by trans* people (Bidell, 2005). Personally knowing someone who is trans*, Post-Graduate Training, and Cismale Gender Identity were all significant in this model. Personally knowing someone who is trans* received the strongest weight in the model (β=.20, r_s=.76), followed by Post-Graduate Training

(β=.16, r_s=.58), followed by Cismale Gender Identity (β=.12, r_s=.35). After examining regression coefficients and corresponding data, the researcher determined that of the 10.3% effect (R^2), personally knowing someone who is trans* accounts for 58.3% of the explained variance by itself A summary of regression coefficients and standard errors can be found in Table 8 (below).

Table 7

Summary of Multiple Regression Three (N=386)

				Change Statistics					
Model	*R*	R^2	*Adj* R^2	Std. Error	ΔR^2	Δ*F*	df1	df2	Sig Δ*F*
3	.321	.103	.089	.88672	.103	7.257	6	379	.000

Notes. Model 3 includes all variables (gender, post-graduate training, PSC work with trans* students, and PSC personal relationships with someone who is trans*) and scores on the Knowledge subscale of the GICCS.

Table 8

Summary of Multiple Regression Three Analysis Coefficients (N=386)

	B	SE_{β}	β
(Constant)	4.683	.102	--
CisMale GI	.476	.221	.105
Trans GI	.690	.522	.065
Agender GI	1.204	.894	.066
Trans Students	.046	.107	.021
Training	.292	.092	.157
Personal	.443	.109	.204

Notes. $p<0.5$, B = unstandardized regression coefficient; SE_β = Standard error of the coefficient; β = standardized coefficient

Research Question Four

Finally, to examine the relationship between PSC factors on skills of PSCs in working with trans* students in schools, the researcher conducted another standard multiple regression analysis (Bremer, 2012; Osborne & Waters, 2002; Laerd Statistics, 2019), using scores from only the Skills subscale of the GICCS as the dependent variable (Bidell, 2005; Bidell, 2012; O'Hara et al., 2013). Again, in this model, several assumptions were tested. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.864. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by VIF values (M=1.03). The researcher identified two (2) studentized deleted residuals greater than ±3 standard deviations (3.34 and 3.02), and filtered out these cases prior to re-running the regression analysis. The researcher determined there were two (2) leverage values greater than 0.2 (.23 and .36), violating normality. The researcher filtered these cases out. The researcher found no values for Cook's distance above one. The assumption of normality was met, as assessed by a Q-Q Plot. Table nine (9) summarizes the change statistics for regression four (N = 387). R^2 for the overall model was 50.2%, with an adjusted R^2 of 49.5%, a medium effect size according to Cohen (1988). PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) significantly predicted skills of PSC self-perceived competency in working with trans* students in schools (as measured by scores on the GICCS Skills

subscale [Bidell, 2012; O'Hara et al., 2013]), $F(6, 380) = 63.945$, $p < .001$. The Skills subscale measures PSC affirmative clinical work with trans* people (Bidell, 2005). Having worked with Trans* students, post-graduate training, and personally knowing someone who is trans* were all significant in this model. Having worked with trans* students received the strongest weight in the model (β=.51), followed by Post-Graduate Training (β=.35), followed by personally knowing someone who is trans* (β=.20). After examining regression coefficients and corresponding data, the researcher determined that of the 50.2% effect (R^2), having worked with trans* students accounts for 79.0% of the explained variance by itself. A summary of regression coefficients and standard errors can be found in Table 10 (below).

Table 9

Summary of Multiple Regression Four (N=387)

	Change Statistics								
Model	*R*	R^2	*Adj* R^2	Std. Error	ΔR^2	ΔF	df1	df2	Sig ΔF
4	.709	.502	.495	.86810	.495	63.945	6	380	.000

Notes. Model 4 includes all variables (gender, post-graduate training, PSC work with trans* students, and PSC personal relationships with someone who is trans*) and scores on the Skills subscale of the GICCS.

Table 10

Summary of Multiple Regression Four Analysis Coefficients (N=387)

	B	SE_{β}	β
(Constant)	1.732	.100	--
CisMales GI	.385	.216	.065
Trans GI	.716	.511	.052

Agender GI	-.699	.875	-.029
Trans* Students	1.482	.105	.513
Training	.845	.090	.346
Personal	.576	.106	.202

Notes. $p<0.5$, B = unstandardized regression coefficient; SE_β = Standard error of the coefficient; β = standardized coefficient

Summary

This chapter discussed the steps in assumption testing and results of data analysis. First, results disprove the null hypothesis for research question one, in that PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) significantly predicted levels of school counselor self-perceived competency in working with trans* students in schools. For research question two, results disprove the null hypothesis, PSC factors significantly predicted awareness. Results for research question three also disproved the null hypothesis, as PSC factors significantly predicted knowledge. Finally, in examining results for research question four, PSC factors significantly predicted skills of PSC self-perceived competency, disproving the null hypothesis. Discussion and implications of the aforementioned analyses are discussed in Chapter 5.

Chapter 5

Discussion

This chapter describes the results of the study with a clear supporting narrative addressing each research question. Additionally, implications for PSCs and counselor education and supervision are discussed. Last, study limitations and directions for future research are presented.

Review of Study

The aim of the present study was to explore the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personally knowing someone who is trans*) on levels of PSC competency in working with trans* students in schools. The purpose of the study is to explore which factors contribute to school counselor competence in working with trans* students, as to better design and implement standardizations in training in counselor education programs, and provide rigorous and appropriate course curriculum in this area. Ultimately, better prepared PSCs may lead trans* students in schools to feel less stigmatized, and enhancing trans* students' positive social, emotional and mental health in schools (GLSEN, ASCA, ACSSW, & SSWAA, 2019; Shi & Doud, 2017; Singh & Burnes, 2009). The data were collected using an electronic survey, over a period of one month, using both the ASCA Online Community, *ASCA Scene,* as well as through ASCA's electronic newsletter, *ASCA Aspects.* The sample in the study included 389 PSCs from the United States, of varying ethnicities and ages, working at various grade levels, with a variety of experiences in working and knowing trans* people, and with a variety of post-graduate training experiences. The following research questions were addressed using a series of

multiple regressions, after cleaning and transforming non-normal data. To that end, this study answered four research questions, discussed below.

Major Findings

Research Question One: PSCs and Gender Identity Competence

The first research question used a standard multiple regression analysis, using SPSS 26. After considering and adjusting for various regression assumptions, the data were analyzed. Results of the multiple regression for research question one indicated statistical significance ($p<.001$), disproving the null hypothesis, that is, the combination of PSC factors contribute significantly to the change in GICCS total scores. This is theoretically consistent, indicating that PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) do contribute to PSC self-perceived competency in working with trans* students (GLSEN, ASCA, ACSSW, & SSWAA, 2019; O'Hara et. al., 2013; Lloyd-Hazlett & Foster, 2013; Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2107; Singh & Burnes, 2009). R^2 was .352, indicating that 35.2% of the variance in the scores on the GICCS variable is explained by the combination of PSC factors in the present sample. The calculated effect size (f^2) for the regression model was .54, indicating a large effect size (Cohen, 1988, 2003), demonstrating practical significance. This explanation of variance contributes to how PSC gender identity competence can be predicted in future studies.

The most salient finding in this model is that PSCs having worked with trans* students was strongly positively correlated with GICCS total scores ($r = .61$, $p<.001$), which may mean more exposure to trans* students increases competency. The researcher found no other studies that directly examine the relationship between PSCs working with

trans* students and their increased competence, however many studies indicate a significant relationship between increased awareness/affirming attitudes towards trans* students and professional exposure to trans* people. Avoiding working with trans* students due to discomfort is not only unethical (ASCA, 2016), but inhibits a PSCs' ability to develop their gender identity competence (Henry & Grubbs, 2016), as the present study demonstrates PSCs who have worked with trans* students are significantly more competent to work with trans* students in the future. Thus, it is imperative PSCs receive the opportunities to work with trans* students (through practicum or internship experiences), consult with experienced, gender-affirming PSCs who have worked with trans* students, and "expose themselves to published texts…films…[and] service-learning activities…to gain a better understanding of the experiences of [trans*] persons" (O'Hara et al., 2013, p.251). Thus, the results of this study support the tenet that increased exposure to trans* people and issues is linked to increased PSC gender identity competency (GLSEN, ASCA, ACSSW, & SSWAA, 2019; Henry & Grubbs, 2016; O'Hara et. al., 2013; Lloyd-Hazlett & Foster, 2013; Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2107; Singh & Burnes, 2009). PSCs who utilize a multi-tier approach to support trans* students are in direct alignment with the ASCA National Model (2019) and can better meet the needs of students at the universal level, work with at-risk students, and through intensive interventions. Thus, it is imperative PSCs engage with trans* students at various levels, and through various methods.

Additionally, post-graduate training was moderately positively correlated with GICCS total score ($r = .43$, $p<.001$), indicating additional post-graduate training in the area of trans* issues increases competency in the present sample (Rutter & Diggs, 2008).

This is consistent with extant literature, which demonstrates PSCs who received post-graduate training are more competent in providing affirming services to trans* students (Salpietro, Ausloos, & Clark, 2019; Lloyd-Hazlett & Foster, 2013; Shi & Doud, 2107). If PSCs do not receive training in working with trans* students (from basic counseling skills, to large-scale advocacy efforts), they are in direct violation of ASCA's *School Counselor Professional Standards & Competencies* (2019), which mandate PSCs demonstrate knowledge of differences in "customs, communications, traditions, values, and other traits among students based on race, religion, ethnicity, nationality, sexual orientation, gender identity, physical or intellectual ability and other factors" (ASCA, 2019, p. 3).

Last, having personal relationships with trans* people was moderately positively correlated with GICCS total scores ($r = .47$, $p<.001$). These results support current literature in that PSCs who have or have had personal relationships with trans* folx (GLSEN, 2019; Henry & Grubbs, 2016; O'Hara et al., 2013; Salpietro et al., 2019) are more competent in providing affirming services to trans* students.

Research Question 2: PSC Gender Identity Awareness

The researcher explored the relationship between PSC factors on the transformed Awareness subscale of the GICCS in the second research question. Results of the multiple regression indicated statistical significance (p=.001), disproving the null hypothesis, that is, the combination of PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) contribute significantly to the change in GICCS Awareness subscale scores. R^2 was .058, which means that 5.8% of the variance in the scores on the GICCS Awareness subscale is

explained by the combination of PSC factors (add those here) in the present sample. The effect size (f^2) for the regression model was .06, indicating a small effect size (Cohen, 1988, 2003), demonstrating practical insignificance. Whereas the results were significant in that it is unlikely the null hypothesis is true (p=.001), the effect size demonstrates the magnitude of the results was small, minimizing the overall significance of this model.

In examining coefficients for the model, having personal relationships with trans* people is associated with a decrease in GICCS Awareness subscale scores, a weak, negative correlation (r = -.19, p=.001). This suggests that people who did *not* know someone personally who is trans* would score slightly higher on the Awareness subscale. These unexpected findings are contrary to existing research, which found that engaging in personal relationships with trans* folx increased affirming attitudes and mitigated negative attitudes (Henry & Grubbs, 2016; Salpietro et al., 2019). No other factors (gender, post-graduate training, PSC work with trans* students) were significant on the GICCS Awareness subscale scores, which may mean that these factors may not be linked to PSCs affirming attitudes and awareness of their own biases (Bidell, 2005). This might also mean that the present sample did not know many self-identified trans* people, and that their levels of Awareness were already high. The researcher found no other studies that examined PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) and PSC awareness of gender identity competence. Due to the lack of practical significance of PSC factors on the Awareness subscale, these results should be cautiously considered.

Research Question 3: PSC Gender Identity Knowledge

In the third research question the researcher explored the relationship between PSC factors on the Knowledge subscale of the GICCS. Results of the multiple regression indicated statistical significance ($p<.001$), disproving the null hypothesis, that is, the combination of PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) contribute significantly to the change in GICCS Knowledge subscale scores. R^2 was .103, which means that 10.3% of the variance in the scores on the GICCS Knowledge subscale is explained by the combination of PSC factors. The effect size (f^2) for the regression model was .11, indicating a somewhat medium effect size (Cohen, 1988, 2003), demonstrating moderate practical significance.

In examining coefficients for the model, PSC Cisgender Male gender identity was moderately positively correlated with the Knowledge subscale scores (r =.476, p=.032), indicating that cismale PSCs scored moderately higher on the Knowledge subscale, when compared with other PSC gender identities in the present sample. One possible explanation is the present study's sample of cisfemales (n=368, 94.6%) and cismales (n=17, 4.4%). Historically, there have been more female-identifying PSCs in schools than male-identifying PSCs (National Association for College Admission Counseling [NACAC], 2014). Within this sample, the ages of the cismale PSCs could reflect a time where counselor education programs increased attention to diversity, whereas this wasn't always a main tenet in training among older PSCs (who may be represented by cisfemale PSCs in this sample (Bemak & Chung, 2008). Additionally, PSC post-graduate training was weakly positively correlated with Knowledge subscale scores, r= .292, p=.002; which supports the literature that PSCs who engage in professional training opportunities

outside of graduate school increase their knowledge of trans* students and trans* issues (Salpietro, Ausloos, & Clark, 2019; Lloyd-Hazlett & Foster, 2013; Shi & Doud, 2107).

Having personal experiences with trans* people was moderately positively correlated with Knowledge subscale scores (r= .434, p<.001), indicating that those PSCs who personally knew a trans* person, felt more confident and competent in their knowledge about trans* students and issues. This supports current literature (GLSEN et al., 2019; Henry & Grubbs, 2016; O'Hara et al., 2013; Salpietro et al., 2019) which finds that PSCs intentionally engaging in and fostering personal relationships with trans* people was linked to increased competence.

Research Question 4: PSC Gender Identity Skills

The researcher explored the relationship between PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) on the Skills subscale of the GICCS in research question four (4). Results of the multiple regression indicated statistical significance (p<.001), disproving the null hypothesis, that is, the combination of PSC factors (gender, post-graduate training, PSC work with trans* students, and PSC personal relationship with someone who is trans*) contribute significantly to the change in GICCS Skills subscale scores. R^2 was .502, which means that 50.2% of the variance in the scores on the GICCS Skills subscale is explained by the combination of PSC factors. The researcher calculated effect size (f^2) for the regression model was 1.01, indicating a very large effect size (Sawilowsky, 2009), demonstrating strong practical significance. While Cohen (1988) originally defined effect size ranging between .2 and .8, current researchers posit effect sizes can range between .01 and 2.0 (Marzano, 2000; as cited in Sawilowsky, 2009).

In examining coefficients for the model, having worked with trans* students was strongly positively correlated with Knowledge subscale scores (r= 1.482, p<.001), which may indicate that PSCs who work with trans* students will be more likely to know the unique and sensitive multisystemic challenges faced by trans* people, and will understand the necessary supports to ensure growth in "…academic, career and social/emotional development…" (ASCA, 2017, para.1). This is supported by literature, in which researchers found the number of students worked with and "…interpersonal contact" (personal exposure) as positive predictors of affirmative counselor competence (Bidell, 2014; Farmer, 2017). This supports the need for counselor education training programs to connect school CITs to practicum and internship opportunities that allow them opportunities to work with trans* students.

Additionally, PSC post-graduate training was strongly positively correlated with Skills subscale scores, (r=.845, p<.001), which may indicate that PSCs who engage in professional development opportunities and trainings gain essential skills for working with trans* students, congruent with literature (Bidell, 2012; Day, 2008; Farmer & Welfare, 2013; Frank & Cannon, 2010; GLSEN, ASCA, ACSSW, & SSWAA, 2019; Graham, 2012; O'Hara et. al., 2013; Lloyd-Hazlett & Foster, 2013; Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2107).

Knowing someone personally who is trans* was moderately positively correlated with Skills subscale scores, r= .576, p<.000, which may mean that having familiarity and exposure to trans* folx increases PSC self-perceived skills.

PSC Gender Identity Competency: Awareness, Knowledge, Skills

In summarizing this study's' implications, the researcher stresses that PSCs' exposure to working with trans* students is imperative. While many studies indicate significant relationships between trans*-affirming attitudes, counselor self-awareness, and professional exposure to trans* people (GLSEN, ASCA, ACSSW, & SSWAA, 2019; Henry & Grubbs, 2016; O'Hara et. al., 2013; Lloyd-Hazlett & Foster, 2013; Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2107; Singh & Burnes, 2009), the present study is emergent in examining a PSC having worked with trans* students as a predictor for increased self-perceived competence.

Additionally, an essential part of PSC gender identity competence is PSC post-graduate training that comprehensively and systemically addresses: unique psycho-social barriers, best clinical practices, rigorous information on transitioning (socially and medically), important ethical and legal issues, affirmative language, and pragmatic interventions and skills in working with trans* folx. Additionally, the trainings should include information from reputable organizations (WPATH, HRC, TLC, NCTE, ALGBTIC), who publish standards, and best practices; in addition to the professional statements and position papers released by ASCA (2016, 2019). Results also indicate that PSC post-graduate training is related to a high increase in skills, and a moderate increase in knowledge of trans* students and/or issues, indicating PSCs are more competent after receiving post-graduate training, especially in skill development.

Another important implication from this study is PSCs having personal relationships with trans* people, outside of their professional roles. While this is challenging to mandate for all PSCs, counselor education programs should provide and support opportunities to interact with trans* folx, engage CITs in working with trans*

students, and connect CITs to transgender groups and communities. O'Hara and colleagues (2013) warn that certain interactions with trans* folx could be "voyeuristic, objectifying, or demeaning" if approached incorrectly, and encourage school counselor CITs to act ethically and use caution in this process (p. 252).

The results of our study also indicate that gender identity is not a significant predictor of PSC gender identity competence within our sample. The only statistically significant relationship was cismale gender identity and an increase in knowledge of trans* issues, which the researcher hypothesizes is linked with PSC age and graduate program diversity training.

Implications for Professional School Counselors

Professional Experiences

Results of this study indicate a significant relationship in the overall model between a PSC having worked with trans* students and an increase in overall self-perceived competency (as measured by the GICCS; Bidell, 2005) in the present sample. Participants who indicated they have worked with a self-identified trans* client scored higher on levels of competency on the overall GICCS. However, results indicate a specific significant link between PSC having worked with trans* students and higher scores on the Knowledge subscale. The GICCS Knowledge subscale addresses PSC knowledge of trans* psychosocial issues (Bidell, 2005). This supports the idea that PSCs who work with self-identified trans* students have a deeper understanding of the social and psychological challenges faced by trans* people, and these experience increase their comfort in working with trans* folx. As the present study demonstrates that PSC professional experiences with trans* students are informative, meaningful, and promote

gender identity competence, it is important for PSCs to engage in work with trans* students during their professional tenure. While PSCs cannot *guarantee* working with a trans* student in their professional work, all PSCs are required to "safeguard the well-being of [trans*] youth" and understand "unique circumstances that often require additional guidance and recommendations" (ASCA, 2016, p.64) and therefore, must have foundational knowledge and familiarity with trans* students and issues. PSCs are in a unique position to foster a safe school climate for trans* students, and provide individual, group and school-wide visibility, resources, and interventions (Henry & Grubbs, 2016). PSCs should offer psychoeducational, support or small counseling groups to non-dominant gender and sexual identities, in addition to promoting clubs like Gender and Sexuality Alliances ([GSA]; Sadowski, 2017). Other ways PSCs can cultivate relationships with trans* students and foster visibility of trans* identities within a comprehensive school counseling program (ASCA, 2019) is by promoting additional school-wide programming specific to trans* students, such as honoring the *Day of Silence, Ally Week,* and *No Name-Calling Week* (GLSEN, n.d.; Henry & Grubbs, 2016), and engaging with affirming organizations, such as *SafeZone*, GSAs, or a local ALGBTIC chapter (O'Hara et al., 2013; Salpietro et al., 2019).

Post-Graduate Training

Results of the study indicate that PSC post-graduate training experiences are significantly linked to an overall increase in scores on the GICCS, indicating that PSC post-graduate experiences contribute to PSCs feeling more confident and competent in working with trans* students. Interestingly, results indicate a relatively weak increase in scores on the Knowledge subscale, but a relatively strong increase when linked with the

Skills subscale scores. While the Knowledge subscale addresses knowledge of trans* psychosocial issues, the Skills subscale measures ones' affirmative clinical work with trans* people (Bidell, 2005). The current study conceptualized post-graduate training experiences as any training or education focused on trans* persons or issues that a PSC received after their graduate program education. The researcher hypothesizes there is a stronger link to skills (rather than knowledge) as many post-graduate training opportunities - continued or continuing professional development (CPD) – offer participants pragmatic skills and interventions (often cited in CPD learning objectives), which are more valued by practitioners. Mulvey (2013) reflects on CPD opportunities as ways to work through specific problems. For example, if a student presents with a new issue or problem, a practitioner may seek out CPD to acquire more skills to better serve the student (Beecher, 1999; Mulvey, 2013). These results indicate that in order to increase competence and provide affirming, ethical care to trans* students, PSCs should engage in some type of post-graduate training on trans* issues and students, especially if they PSCs are unfamiliar with trans* issues. These results are congruent with other studies, which found insignificance in the relationship between groups on the Awareness scale, but significant relationships on both the Knowledge and Skills subscales with professional training experiences (Bidell, 2005; Rutter & Diggs, 2008). One study even purports the inclusion of *experience* (involvement and engagement in practice) as an additive factor (with Awareness, Knowledge, and Skills) for PSC training and effective practice with diverse students (Ali, Lambie, & Bloom, 2017). PSCs are encouraged to join professional organizations that promote best-practices in working with trans* students, as these organizations often offer affirming professional development and/or

CPD opportunities, like the World Professional Association for Transgender Health (WPATH), the Human Rights Campaign (HRC), the Transgender Law Center (TLC), the National Center for Transgender Equality (NCTE), and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC). ASCA (2016, 2019) dictates PSCs have a professional responsibility to "monitor and expand personal multicultural and social-justice advocacy awareness, knowledge, and skills to be an effective culturally competent school counselor" (Standard B.3.i., 2016), thus it is imperative PSCs engage in professional development training opportunities on trans* issues. This tenet is supported by current literature, which demonstrate the important relationship between consistent professional development and gender identity competence (ASCA, 2016, 2019; O'Hara et. al., 2013; Lloyd-Hazlett & Foster, 2013; Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2107). Last, it is essential that PSCs seek out trainings that are specific to trans* students and issues, attending to unique psychosocial barriers, best practices, social/medical transitioning, ethical/legal issues, affirming language, interventions, and skills.

Personal Relationships

Of all the variables in the present study, PSCs knowing someone who identifies as trans* was significantly linked to an increase in overall confidence and competence (GICCS Total scores), as well as a significant increase in both Knowledge and Skills. Surprisingly, results of this study demonstrate a statistically significant small decrease in Awareness subscale scores among those PSCs who indicated they know someone who is trans*. That is, PSCs who indicated they did *not* know someone who identified as trans* scored slightly higher on the Awareness subscale scores when compared with PSCs. The

Awareness subscale of the GICCS examines a PSC's self-awareness of anti-trans* biases and stigmatization (Bidell, 2005). This result is contrary to existing research, which found that engaging in personal relationships with trans* folx increased affirming attitudes and mitigated negative attitudes (Henry & Grubbs, 2016; Salpietro et al., 2019).

The link between PSC personally knowing someone who is trans* and a counselors competency in knowledge and skills supports extant literature which speaks to the importance of non-work related experiences with trans* people (ie., personal, familial and social) and an increase in counselors' competence in working with trans* students (Whitman & Han, 2016). Additional studies support the links between personal relationships with trans* folx and increased knowledge of trans*-related issues (Salpietro, Ausloos, & Clark, 2019) and increased advocacy skills (O'Hara et al., 2013; Payne & Smith, 2014). It is important PSCs continue to monitor and increase their personal engagement with the trans* communities, as this significantly links to PSCs feeling more comfortable and more competent in working with trans* students. Personal experiences may include fostering connections to trans* family members, friends, and trans* people through community organizations (GLSEN, 2019; Henry & Grubbs, 2016; Salpietro, Ausloos, & Clark, 2019), so it is important PSCs are connected to local and regional resources in their communities.

Gender Identity

Literature demonstrates that there is a relationship between sexual identities (both dominant and non-dominant) and attitudes towards non-dominant sexual identities; for example, gay women have more favorable attitudes towards gay people in general, while gay men hold unfavorable attitudes towards other gay men, but hold more positive

attitudes towards lesbians (Anderson, 2009; Cuddy & Fiske, 2004). Other researchers have found relationships between gender role conflicts (specifically men) and attitudes towards counseling and counselors (Gillen, 2012; Landes, Burton, King, & Sullivan, 2013; Phoenix, 2014; Wisch & Mahalik, 1999; Wisch, Mahalik, Hayes, & Nutt, 2004). No previous studies explored gender identity and counselor gender identity competency. The researcher of this study found one significant relationship between PSC gender identity, specifically CisMale gender identity, which was linked to a moderate, positive increase in Knowledge subscale scores. While this result may be spurious, overall links to gender identity and counselor competence were not present. This demonstrates that gender identity may not play a major part in PSCs self-perceived competence to work with trans* students, however this should be explored further. This finding does not support previous literature, which found "cisgender men invest in hegemonic masculinity", contributing to less positive attitudes towards trans* folx (Riggs & Sion, 2016; Kucharska & Marczak, 2017).

Implications for Counselor Education and Supervision

Results of this study have implications for counselor education (CE), preparation and supervision programs. This section will highlight important implications for CE programs, curricula, and CIT field work.

Multicultural and Diversity Courses

There are several important implications for counselor education training programs who work with school CITs. First, the researcher was intentional in not examining a variable of PSCs having received formal graduate-level training (e.g., multicultural and diversity courses), as literature demonstrates engagement in these

courses is not strongly linked to counselor competency in working with diversity, specifically LGBTQ students (Bidell, 2005; Day, 2008; Farmer & Welfare, 2013; Frank & Cannon, 2010; GLSEN, ASCA, ACSSW, & SSWAA, 2019; Graham, 2012; Lloyd-Hazlett & Foster, 2013; O'Hara et al., 2013). Post-graduation, PSCs often seek out informal professional development and training opportunities in order to supplement their formal education and foster competence in working with trans* students (Salpietro, Ausloos, & Clark, 2019; Shi & Doud, 2017). The present study's results indicate that those PSCs who engage in professional development are more competent than those who do not. Professional counseling organizations (ASCA) and councils (CACREP) mandate that school CITs receive formal training in social and cultural diversity (CACREP F.2, 2016) including multicultural counseling competencies (F.2.c.; CACREP, 2016), and deliver a comprehensive "counseling program that advocates for and affirms all students…including:…gender, gender identity and expression" (ASCA, 2016, para. 3).

Numerous organizations have published standards and competencies related to working with trans* people, which should be utilized and reflected upon in all courses: *The WPATH Standards of Care* (2011), the *ALGBTIC Competencies for Counseling with Transgender Students* (2009); the *ACA Advocacy Competencies* (2003), the *American Psychological Association (APA) Report of the Task Force on Gender Identity and Gender Variance* (2009), the *ASCA Ethical Standards for School Counselors* (2016), and the *ASCA Position Statement on The School Counselor and Transgender/Gender-nonconforming Youth* (2016).

While these call for the inclusion of LGBTQIA+ issues within counselor education curricula, the reality is that CITs (CITs) receive minimal training in working

with trans* and gender-expansive students (Bidell, 2012; Frank & Cannon, 2010; O'Hara et. al., 2013). Therefore, it is imperative CE programs and counselor educators broaden the scope of learning about trans* issues, going beyond the minimal requirements (CACREP, 2016), providing depth and rigor in gender-related coursework in diversity courses. Researchers note the importance of rigorous training that attends to family systems, intersectionality of trans* people, and social and medical issues while transitioning (Salpietro, Ausloos, & Clark, 2019). This research supports other emergent literature which recommends counselor education programs offer additional, specific courses related to affective and sexual identities (LGBQ+), and gender-expansive identities (trans*, GE), as covering specific issues and populations increases counselor competency (Bidell, 2014a; Henry, 2018; O'Hara et al., 2013, Salpietro et al., 2019).

Unfortunately, there is often a lack of conversation about trans* and gender-related issues in counseling courses, due to fear of embarrassment or stigma (O'Hara et al., 2013). Therefore, it is within the purview of the course facilitator to create a safe space for honest self-reflection and learning (Miller, Miller, & Stull; 2007). It is also imperative counselor educators themselves are intentional in challenging and changing their assumptions and fears (Frank & Cannon, 2010), and modeling this to school CITs.

Additionally, as the worldview of a cisgender counselor educator greatly influences the way in which they teach, it is advised that counselor educators foster representation and visibility of trans* identities and invite trans*-identified speakers and educators to the classroom (O'Hara et al., 2013), which fosters personal connections as well as provides school CITs with increased knowledge and skills. Another important part of CE training programs addressing trans* issues is "clearly and intentionally

includ[ing] the LGBT population within the scope of multicultural counseling and training" including infusing trans* and GE identities in case studies, examples, and class discussions (Troutman & Packer-Wiliams, 2014). Counselor educators should intentionally mitigate historically cis- and hetero-normative language and examples used in courses (Goodrich et al., 2013; Gonzalez & McNulty, 2010; Henry & Grubbs, 2016 Singh & Burnes, 2009), using inclusive, person-first language and diverse relationship systems. As counselor educators model inclusive and trans*-affirming curriculum, school CITs will feel better prepared to implement these foundations at their future schools, as many people need to see examples of ally-ship and success in the classrooms prior to implementation themselves (Thein, 2013; as cited in Henry & Grubbs, 2016). It is important to note the infusion of trans* identities and unique issues into counselor education should be demonstrated in all CACREP content areas (in addition to multicultural and diversity courses), including human growth and development (i.e, gender identity development, challenges faced in families with trans* youth), career development (i.e., unique barriers faced by trans* people in the workforce), and counseling and helping relationships (i.e., affirmative counseling, strengthening the therapeutic relationship with trans* students; CACREP, 2016).

Last, CE programs should utilize a variety of assessments in determining multicultural skills and competence in working with diverse populations, specifically trans* people. While scales have been created to assess attitudinal awareness and beliefs towards non-dominant sexual identities, such as the Sexual Orientation Beliefs Scale ([SOBS]; Arseneau, 2013) and the Heteronormative Attitudes and Beliefs Scale ([HABS]; Habarth, 2014), the GICCS (Bidell, 2005) is the only current measure for

gender identity counselor competency. Researchers recommend using a variety of "tests, quizzes, reports, presentations, reflection journals, [and] serving learning activities" to facilitate learning and growth (Celinska & Swazo, 2016, p. 20). In this way, CE programs can more consistently assess and provide interventions to CITs throughout their training to increase their competence.

Enhancing Connections with the Trans* Communities & Resources

As the present study highlights, PSCs personally knowing someone who is trans* is an important link to increased competency in working with trans* students. Of all the variables, this one had the most significant links to increased scores on subscales and GICCS total scores. While counselor educators cannot mandate that CITs engage personally with trans*-identifying folx, it is important for counselor educators to assist in fostering connections to trans*-affirming accessible groups (GLSEN, 2019; Henry & Grubbs, 2016; Salpietro, Ausloos, & Clark, 2019). Programs should encourage engagement in non-work related experiences with trans* people, fostering connections to trans* family members, friends, and trans* community members. Ethical considerations should be made for virtual connections, with programs with limited access to guest speakers or gender-diverse persons, using "computer programs, internet programs, teleconferencing, and smartphone applications…" to connect with trans* folx (Aboujaoude, Salame, & Naim, 2015, p. 223). Other researchers recommend experiential assignments in diversity courses to include engagement with organizations that focus on "[trans*] awareness, safety, advocacy, and support" (ie., clubs, places of worship, non-profits, support groups; O'Hara et al., 2013).

It is also important that counselor education programs connect CIT's to field work placements that work with trans* folx throughout the lifespan (for practicum and internship settings). While this requires extra work, counselor education programs should assess practicum and internship settings for types of students worked with at that location, and the framework with which they work with LGBTGEQIAP+ students. While this may be more challenging with school systems, counselor education programs can view school district policies regarding gender identity and expression, noting the presence or absence of inclusive, affirming language and procedures (Goodrich et al., 2013; Henry & Grubbs, 2016; Lambda Legal, n.d.).

Supervision and Supervision Training

Supervision is a required element of the counseling profession for clinical (ACA, 2014) and school counselors (ASCA, 2016, 2019). However, there is great concern over irregular supervision requirements among states and school districts (Wambu & Myers, 2019). While post-graduate clinical supervision isn't required for school counselors (ASCA, 2016), these results have implications for PSC supervisors and supervision training for school counselors in training. While school counselor supervision preparation has received increased attention in the last few years (Spinella, 2015), historically, school counselors do not receive training in supervision and therefore, are sometimes practicing "outside the range of their professional competence" (ASCA, 2016; Wambu & Myers, 2019). CE programs have a responsibility to train CITs to be professional counselors, which includes learning foundations and skills in PSC supervision. Among these skills, is the importance of working with non-dominant populations, ASCA (2016) mandates "[advocating] for the equal right and access to free, appropriate public education for all

youth, in which students are not stigmatized or isolated…" (Standard A.10.a). As this study demonstrates, PSCs and PSC supervisors should seek out professional post-graduate training opportunities that focus on trans* students and issues. Also, PSC supervisors should assist supervisees in fostering personal relationships with trans* people, by providing resources, making connections with and for the supervisee, and continuing to support the supervisee in their own journey establishing personal relationships with trans* folx (Shi & Doud, 2017). An important part of supervision is consistent didactic assessment of supervision process; and supervisor/supervisee awareness, knowledge and skills (Spinella, 2015). Supervisors should consider the Supervision Outcome Scale (SOS), as a measure of assessing improvement in supervisee competence, specifically multicultural competence (Tsong & Goodyear, 2014). Supervisors of school CITs should engage in their own self-reflection and assessment as an important part of ethical and meaningful supervision (Prasko, Mozny, Novotny, Slepecky & Vyskocilova, 2012). One important piece of supervisor competence is seeking consultation and supervision (O'Hara et al., 2013), both in supervision and multicultural components. Research indicates supervisors who seek additional supervision training, and/or seek supervised supervision experience increased competence and understanding of roles in supervision and are more sensitive to their supervisees' needs (Borders, 2005; Tsong & Goodyear, 2014).

Supervision experiences of school CITs should support graduate training awareness, knowledge and skills, including opportunities for exploring biases and expanding awareness of privilege, power, and marginalization as it relates to gender identity (O'Hara et al., 2013; Spinella, 2015), through informal (discussions, reflections,

triadic supervision) and/or formal strategies (presentations, screening tools, scales and assessments; Celinska & Swazo, 2016).

Study Limitations

There are several limitations to consider with this study, related to both internal and external threats to validity. Internal threats to validity are procedures in the study or experiences of participants that threaten the ability to draw correct inferences from data about a phenomenon, while external threats to validity relate to incorrect inferences applied to other populations and future situations (Creswell, 2013). While the author has made every effort to make item wording clear, concise and concrete, additional limitations are social desirability factors (presenting oneself in an overly positive way; Crowne & Marlowe, 1964) and inattentive responding, which may have influenced the quality of the data, as the study relies on self-report (McKibben & Silvia, 2016). While many researchers use the Marlowe-Crowne Social Desirability Scale (MCSDS) as a scale to measure the influence of potential socially desirable responses, findings demonstrate there may issues with the measurement properties of the MCSDS scale, in that it is "unable to predict socially desirable behavior once adjustments are made for common sources of measurement error" (Nolte, Elsworth, & Osborne, 2013; Johnson & Fendrich, 2002, p.1664). Additionally, researchers found a strong association between MCSDS scores and demographic variables, like education, racial-ethnic identity, and age; accounting for some of the variability in its' accuracy (Johnson & Fendrich, 2002). Therefore, it was not used in this study. Additionally, the author is aware of the possibility of drawing incorrect inferences from the sample data to the general population of PSCs (interaction of selection and treatment), a threat to external validity of the study

(Creswell, 2013). While a growing number of states require schools to provide school counseling services, as of 2019, PSCs are not mandated in every state, which contributes to lack of consensus of professional identity, role confusion, and an inability to draw correct inferences from this study to all PSCs (American Counseling Association, 2011; ASCA, 2019).

The researchers are aware that the use of the term trans* as an umbrella term conflates the unique and diverse identities of gender-expansive individuals. In schools, someone who identifies as a transgirl has varied experiences when compared with someone who identifies as non-binary, and these experiences deserve exploration in separate studies.

Finally, the revised Gender Identity Counselor Competency Scale (GICCS) has not been used in many studies focusing on trans* populations and additional research is needed to assess its' validity with this population and with the professional school counselor population (Bidell, 2005; Corr, 2016).

Recommendations for Future Research

While the present study confirmed that certain professional and personal factors contribute to PSCs increased competence in working with trans* students in the present sample, additional research should be conducted. As previously mentioned, the revised Gender Identity Counselor Competency Scale (GICCS) has not been used in many studies focusing on trans* populations and additional research is needed to assess its' validity with PSCs and trans* youth (Bidell, 2005; Corr, 2016).

Future researchers should consider additive studies that more deeply examine the types of professional development and CPD that promote PSC competency including

length of CPD, location of CPD, modality, themes, and expertise of presenter(s). Knowing these factors is important for crafting and delivering meaningful and competence-fostering professional development opportunities. While this study supports the fact that PSCs frequently seek out professional trainings and workshops, future research should explore if PSCs are attending workshops for continuing education units (CEUs), self-improvement, for a specific client, or if required by place of employment. Additionally, the researcher supports GLSEN (2019) in calling for future research that explores the influence of knowing LGBTQ people in a personal way on affirming attitudes. While this study asked about a PSC personally knowing someone who is trans*, future studies should examine the types and nuances of those relationships. Future studies should also demographic factors like religiosity and spirituality and their correlation to PSC gender identity competence, building on the work by Farmer (2017).

There are presently several adult-focused standards and competencies in working with trans* folx, however researchers should, through a grounded theory research design, develop and competencies for transition-aged trans* youth, who have unique and intersectional needs.

Additionally, researchers should examine counselor education programs and investigate what makes school CITs feel competent as they become PSCs within their graduate training. Last, school CITs should be exposed to supervisory foundational models and ethics, as they will most likely be a PSC supervisor in their professional work. Counselor education programs have a requirement to attend to how supervisors work with their supervisees with non-dominant, marginalized populations, including the trans* populations.

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Appendix A

Participant Recruitment

(*ASCA Scene & ASCA Aspects*)
Call for Participants
Dear Licensed Professional School Counselors,

My name is Clark Ausloos, and I am a doctoral candidate in the Counselor Education program at the University of Toledo. I intend to recruit a diverse sample of currently practicing licensed professional school counselors for my research entitled Professional School Counselors' Levels of Self-Perceived Competence in Working with Trans* Students in K-12 Public Schools. The research study has been submitted, reviewed, and approved by the Institutional Review Board (IRB#: XXXX) at the University of Toledo and is under the supervision of Dr. Madeline Clark (madeline.clark@utoledo.edu).

This purpose of this study is to explore and better understand the experiences of licensed professional school counselors and their levels of competence in working with trans* students, based on post-graduate training, internship experiences, and personal exposure and experiences with trans* individuals. I hope that information gathered from this study can contribute to improved training experiences of school counselors through counselor education programs, through knowing which experiences are meaningful and contribute to increased confidence and competency. Ultimately, increased competence contributes to safer and affirming spaces for trans* students in schools, a highly vulnerable population.

To qualify for the study, you must currently be a licensed professional school counselor in the United States, working in a K-12 Public School setting. Participants who successfully complete the study and provide an email address will be entered in a drawing to receive a $10 Amazon E-Gift Card (100 winners will be drawn at random, one card per participant, sent within one month of completing the survey). Participants who withdraw from the study prior to completing will not be eligible for compensation. The survey link below connects to Qualtrics (which contains an informed consent agreement, demographic questions, and the Gender Identity Counselor Competency Scale, GICCS).

Link: XXXXXXXXX

QR Code: XX

Thank you!

Clark D. Ausloos

Clark D. Ausloos, Doctoral Candidate, Counselor Education, clark.ausloos@utoledo.edu
Madeline Clark, Assistant Professor, Counselor Education, madeline.clark@utoledo.edu
School of Intervention and Wellness, College of Health and Human Services
The University of Toledo

Appendix B

Informed Consent Form

IRB # XXXXXX

ADULT RESEARCH SUBJECT - INFORMED CONSENT FORM
Professional School Counselors' Levels of Self-Perceived Competence in Working with Trans* Students in K-12 Public Schools

Principal Investigator:
Clark D. Ausloos, MA, LPC, Doctoral Candidate, (920) 948-2467
Dr. Madeline Clark (faculty), Assistant Professor, (419) 530-4773

Purpose: You are invited to participate in the research project titled, Professional School Counselors' Levels of Self-Perceived Competence in Working with Trans* Students in K-12 Public Schools, a study which is being conducted at the University of Toledo under the direction Dr. Madeline Clark (faculty member), and Clark D. Ausloos (principal investigator, doctoral candidate). This purpose of this study is to explore and better understand the experiences of licensed professional school counselors and their levels of competence in working with trans* students, based on post-graduate training, internship experiences, and personal exposure and experiences with trans* individuals.

Description of Procedures: If you meet criteria for the study, you will be directed to a Qualtrics link. We expect your involvement in our study will take approximately 15-20 minutes, or until yo have completed all components of the survey package online. You will be provided with an informed consent document, a basic demographic questions, and to complete the Gender Identity Counselor Competence Scale (GICCS) using the link. After you finish the questionnaire and GICCS, you will be asked to enter an email address, to which we will send the $10 Amazon E-Gift Card, if you are selected. (Once completed, you will be entered in the drawing for a chance to win this incentive).

Potential Risks: There are minimal risks to participation in this study, including loss of confidentiality. It is possible that some participants may experience some level of distress as a result of being asked to answer self-perceived competency levels related to trans* experiences.
Though the survey is completely confidential, some participants may experience feelings of guilt or shame if they do not respond according to the beliefs of their counseling program or the counseling field at large. You may withdraw from the study at any time.

Potential Benefits: We hope that information gathered from this study can contribute to improved training experiences of school counselors through counselor education programs, through knowing which experiences are meaningful and contribute to increased confidence and competency. Ultimately, increased competence contributes to safer and affirming spaces for trans* students in schools, a highly vulnerable population.

Participation entitles you to be entered in a drawing to receive one of 100 gift cards to Amazon.com for $10 each. If you are interested in being entered into the drawing, following the completion of the survey, you will be provided an email address to contact directly, expressing your interest. This information will not be linked to your responses. Winners will be chosen at random by the researcher, and if you win, you will receive the gift card within one month of successfully completing the survey.

Confidentiality: Confidentiality will be a vital part of this study. Data will be stored on the primary researcher's laptop via software packages including SPSS and Qualtrics. The laptop is password protected. Data will only be accessed by the primary researcher and principal investigator. For publication and presentation purposes, data will be aggregated and summarized. No individual responses will be communicated. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

Voluntary Participation: Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with The University of Toledo. In addition, you may discontinue participation at any time without any penalty or loss of benefits. If you decide to withdraw, you will not be eligible for the $10 Amazon E-Gift Card.

Contact Information: Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation or experience any physical or psychological distress as a result of this research you should contact a member of the research team: Clark Ausloos, (920) 948-2467, or
Dr. Madeline Clark (419) 530-4773.

If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, the Chairperson of the SBE Institutional Review Board may be contacted through the Office of Research on the main campus at (419) 530-2844.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

CONSENT SECTION – Please read carefully

You are making a decision whether or not to participate in this research study. Clicking the "Yes" box indicates that you have read the information provided above, you have had all your questions answered, and you have decided to take part in this research. Do you consent to take part in this research?

YES NO

(This Adult Research Informed Consent document has been reviewed and approved by the University of Toledo Social, Behavioral and Educational IRB for the period of time specified in the box below. Approved Number of Subjects: _____.)

Appendix C

Professional School Counselor Demographic Questionnaire

1. What is your age (as of today) in years? _____

2. How do you describe your gender identity? _____

2. Which categories describe you?

☐ American Indian or Alaska Native—For example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community;

☐Asian—For example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese

☐ Black or African American—For example, Jamaican, Haitian, Nigerian, Ethiopian, Somalian

☐ Hispanic, Latino or Spanish Origin—For example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Columbian

☐ Middle Eastern or North African—For example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian

☐ Native Hawaiian or Other Pacific Islander—For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese

☐ White—For example, German, Irish, English, Italian, Polish, French;

☐ Some other race, ethnicity, or origin, please specify: _____

☐ prefer not to answer

3. As of today, how long have you been working as a professional school counselor, in years?: _____

4. What is the location in which you currently practice as a professional school counselor?

☐ Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, North Dakota, South Dakota, Wisconsin

☐ Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

☐ South—Arkansas, Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

☐ West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

☐ Puerto Rico or other U.S. territories

☐ Other, please specify: _____

5. What is the grade-level in which you work? (Select all that apply):

☐ Elementary, or primary school setting

☐ Middle School setting

☐ High School setting

☐ Other, please specify: _____

Please answer "yes" or "no" to the following questions:

6. Have you worked with trans* clients during your professional tenure as a PSC? (Note: trans* identities can represent a variety of gender identity and expressions) Yes *or* No

7. Have you received post-graduate training addressing trans* issues?

(Note: These are experiences after graduate school, conceptualized as workshops or panels at conferences, professional development, continuing education, and/or in-service opportunities offered by schools or other professional organizations that are focused on trans* issues and/or students) Yes *or* No

8. Do you personally know someone who identifies as trans* who is *not* a student in the K-12 school setting? Yes *or* No

Appendix D

Gender Identity Counselor Competency Scale

O'Hara, C., Dispenza, F., Brack, G., Blood, R.A.C. (2013)

Instruction: Using the provided scale, rate the truth of each item as it applies to you. It is important to provide the most candid response, often your first one.

1. I have received adequate clinical training and supervision to work with transgender clients/patients.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

2. The lifestyle of a transgender individual is unnatural.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

3. I develop my clinical skills regarding transgender clients/patients via consultation, supervision, and continuing education.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

4. I have experience working with transgender clients/patients.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

5. Transgender clients/patients receive less preferred forms of clinical treatment than non- transgender individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

6. At this point in my professional development, I feel competent, skilled, and qualified to work with transgender clients/patients.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

7. I have experience working with transgender couples and/or families.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

8. I have experience working with male to female transgender individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

9. I am aware some research indicates that transgender individuals are more likely to be diagnosed with mental illnesses than are non-transgender individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

10. A transgender person is not as psychologically stable as a non-transgender person.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

11. Being highly discreet about their gender identity and expression is a trait that transgender individuals should work towards.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

12. I have been to professional in-services, conference sessions, or workshops focusing on transgender issues.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

13. Prejudicial concepts about gender have permeated the health professions.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

14. I feel competent to assess a person who is transgender in a therapeutic setting.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

15. Transgender people don't need special rights (e.g., employment, marriage, housing, or legal).

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

16. There are different issues (i.e., psychosocial, medical) impacting male-to-female versus female-to-male transgender individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

17. It would be best if my clients/patients viewed traditional gender expression as ideal.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

18. I have experience working with transgender female to male individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

19. I am aware of institutional barriers that may inhibit transgender people from using healthcare services.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

20. I am aware that healthcare practitioners impose their values concerning gender upon transgender clients/patients.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

21. My clients/patients should accept some degree of conformity to traditional gender roles and expression.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

22. Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were a transgender individual.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

23. Transgender individuals will benefit most from a provider endorsing conventional values and norms about gender.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

24. Being born a non- transgender person in this society carries with it certain advantages.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

25. Gender identity differences between providers and clients/patients may serve as an initial barrier to effective clinical care with transgender individuals.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

26. I have done a training role-play involving a transgender clinical issue.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

27. I think being transgender is a mental disorder.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

28. Transgender individuals must be discreet about their gender identity and expression around children.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

29. When it comes to transgender individuals, I believe they are morally deviant.

Not at all True			Somewhat True			Totally True
1	**2**	**3**	**4**	**5**	**6**	**7**

Appendix E

Master Correlation Table

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. CisFemale GI	-	-.895**	-.369**	-.213**	-.106*	-.013	-.079	-.143**	-.143**	-.152**	.001	.115*	.146**	.067	.013	.096	-.085	-.019
2. CisMale GI	--	--	-.019	-.011	.089	.039	-.002	.105*	.121*	.112*	.021	-.084	-.117*	-.025	.001	-.118*	.091	.049
3. Trans GI	--	--	--	-.004	.049	-.029	.157**	.108*	.096	.090	-.041	-.055	-.067	-.084	-.053	-.009	.021	-.035
4. Agender GI	--	--	--	--	.028	-.050	.091	.026	-.015	.074	-.021	-.078	-.064	-.053	.029	.064	-.028	-.054
5. Trans Clients	--	--	--	--	--	.080	.071	.407**	.545**	.065	-.109*	.050	.061	.110*	-.048	-.442**	.033	.363**
6. Training	--	--	--	--	--	--	.143**	.361**	.407**	.188**	-.104*	-.058	-.041	-.011	.041	-.057	.016	.024
7. Personal	--	--	--	--	--	--	--	.346**	.286**	.247**	-.218**	-.098	-.041	-.124*	.068	.002	-.007	-.030
8. GICCS Total	--	--	--	--	--	--	--	--	.827**	.655**	-.647**	-.241**	-.016	-.161**	-.012	-.199**	-.024	.184**
9. Skills	--	--	--	--	--	--	--	--	--	.303**	-.255**	-.101*	-.014	-.044	-.015	-.312**	-.010	.284**
10. Knowledge	--	--	--	--	--	--	--	--	--	--	-.310**	-.323**	-.014	-.248**	.018	.014	-.051	-.023
11. Awareness	--	--	--	--	--	--	--	--	--	--	--	.179**	.008	.117*	.035	.028	.000	-.032
12. Age	--	--	--	--	--	--	--	--	--	--	--	--	.120*	.708**	.092	-.037	-.076	.079
13. Ethnocultural	--	--	--	--	--	--	--	--	--	--	--	--	--	.143**	-.120*	.012	.033	.036
14. Years as PSC	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-.035	-.091	-.064	.070
15. PSC Region	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.000	-.007	.005

16. Elementary	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-.046	-.686**
17. Middle School	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-.267**
18. High School	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Note. GICCS = Gender Identity Competency Scale (Bidell, 2005). * = (p< .05), **=(p< .001). += a transformed variable